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Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 414, et al. Medicare: Hospital Outpatient Prospective Payment System and CY 2007 Payment Rates; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 414, 416, 419, 421, 485, and 488

[CMS–1506–P; CMS–4125–P]

RIN 0938–AO15

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

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system, and to implement certain related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, and the Deficit Reduction Act (DRA) of 2005. The proposed rule describes proposed changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. These changes would be applicable to services furnished on or after January 1, 2007.

In addition, this proposed rule would revise the current list of procedures that are approved when furnished in a Medicare-approved ambulatory surgical center (ASC), which would be applicable to services furnished on or after January 1, 2007. Further, this proposed rule would revise the ASC facility payment system to implement provisions of the MMA and other applicable statutory requirements, and update the ASC payment rates. Changes to the ASC facility payment system and the payment rates would be applicable to services furnished on or after January 1, 2008.

This proposed rule would revise the emergency medical screening requirements for critical access hospitals (CAHs).

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

This proposed rule would also continue to implement the requirements of the DRA that require that we expand the ''starter set'' of 10 quality measures that we used in FY 2005 and FY 2006 for the hospital Inpatient Prospective Payment System (IPPS) Reporting Hospital Quality Data for the Annual Payment Update (RHQDAPU) program. We began to adopt expanded measures effective for payments beginning in FY 2007. We are proposing to add additional quality measures to the expanded set of measures for FY 2008 payment purposes. These measures include the HCAHPS® survey, as well as Surgical Care Improvement Project (SCIP, formerly Surgical Infection Prevention (SIP)), and Mortality quality measures.

DATES: To be assured consideration, comments on all sections of the preamble of this proposed rule, except section XVIII. and section XXIII., must be received at one of the addresses provided in the **ADDRESSES** section, no later than 5 p.m. October 10, 2006.

To be assured consideration, comments on section XVIII. of this preamble relating to the proposed revised ASC payment system and the related regulation changes for implementation January 1, 2008, must be received at one of the addresses provided in the **ADDRESSES** section, no later than 5 p.m. on November 6, 2006.

ADDRESSES: In commenting on all provisions except those found in section XXIII. of the preamble, please refer to file code CMS–1506–P. In commenting on the provisions found in section XXIII. of the preamble for the FY 2008 IPPS RHQDAPU program, please refer to file code CMS–4125–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Submit electronic comments on CMS regulations with an open comment period.'' (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1506–P, or CMS–4125–P, P.O. Box 8011, Baltimore, MD 21244–1850.

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

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1506–P, or CMS–4125–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses: Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

Submission of Comments on Paperwork Requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided 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.
Dana Burley, (410) 786–0378, Ambulatory surgery center issues.
Suzanne Asplen, (410) 786–4558, Partial hospitalization and community mental health centers issues.
Mary Collins, (410) 786–3189, Critical access hospital emergency medical planning issues.
Sandra M. Clarke, (410) 786–6975, Medicare Administrative Contractors issues.
Mark Zobel, (410) 786–6905, Medicare Administrative Contractors issues.
Liz Goldstein, (410) 786–6665, FY 2008 IPPS RHQDAPU HCAHPS® issues.
Bill Lehrman, (410) 786–1037, FY 2008 IPPS RHQDAPU HCAHPS® issues.
Sheila Blackstock, (410) 786–3506, FY 2008 IPPS RHQDAPU SCIP and mortality issues.

SUPPLEMENTARY INFORMATION: comments from the public on all issues set forth in this proposed rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1506-P or file code CMS–4125-P for FY 2008 RHQDAPU program issues, and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking.* Click on the link ''Electronic Comments on CMS Regulations'' on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244, on Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Alphabetical List of Acronyms Appearing in the Proposed Rule

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
APC Ambulatory payment classification
AMP Average manufacturer price
ASC Ambulatory Surgical Center
ASP Average sales price
AWP Average wholesale price
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BBRA Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, Pub. L. 106–113
BCA Blue Cross Association
BCBSA Blue Cross and Blue Shield Association
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
CAH Critical access hospital
CBSA Core-Based Statistical Area
CCR Cost-to-charge ratio
CMHC Community mental health center
CMS Centers for Medicare & Medicaid Services
CNS Clinical nurse specialist
CORF Comprehensive outpatient rehabilitation facility
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2006, copyrighted by the American Medical Association
CRNA Certified registered nurse anesthetist
CY Calendar year
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DMERC Durable medical equipment regional carrier
DRA Deficit Reduction Act of 2005, Pub. L. 109–171
DSH Disproportionate share hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
EPO Erythropoietin
ESRD End-stage renal disease
FACA Federal Advisory Committee Act, Pub. L. 92–463
FAR Federal Acquisition Regulations
FDA Food and Drug Administration
FFS Fee-for-service
FSS Federal Supply Schedule
FY Federal fiscal year
GAO Government Accountability Office
HCPCS Healthcare Common Procedure Coding System
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IDE Investigational device exemption
IPPS [Hospital] Inpatient prospective payment system
IVIG Intravenous immune globulin
MAC Medicare Administrative Contractors
MedPAC Medicare Payment Advisory Commission
MDH Medicare-dependent, small rural hospital
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
NCCI National Correct Coding Initiative
NCD National Coverage Determination
NTIOL New technology intraocular lens
OCE Outpatient Code Editor
OMB Office of Management and Budget
OPD [Hospital] Outpatient department
OPPS [Hospital] Outpatient prospective payment system
PA Physician assistant
PHP Partial hospitalization program
PM Program memorandum
PPI Producer Price Index
PPS Prospective payment system
PPV Pneumococcal pneumonia (virus)
PRA Paperwork Reduction Act
QIO Quality Improvement Organization
RFA Regulatory Flexibility Act
RHQDAPU Reporting hospital quality data for annual payment update
RHHI Regional home health intermediary
SBA Small Business Administration
SCH Sole community hospital
SDP Single Drug Pricer
SI Status indicator
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
TOPS Transitional outpatient payments
USPDI United States Pharmacopoeia Drug Information

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

included in sections XVII,. XVIII., and XXIV. through XXVII. of the preamble and in Addenda AA, BB, and CC of the proposed rule.

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

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Addendum E—Proposed CPT Codes That Are Paid Only as Inpatient Procedures

I. Background for the OPPS

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

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

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

The OPPS was first implemented for services furnished on or after August 1, 2000. Implementing regulations for the OPPS are located at 42 CFR Part 419.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service

basis that varies according to the ambulatory payment classification (APC) group to which the service is assigned. We use Healthcare Common Procedure Coding System (HCPCS) codes (which include certain Current Procedural Terminology (CPT) codes) and descriptors to identify and group the services within each APC group. The OPPS includes payment for most hospital outpatient services, except those identified in section I.B. of this preamble. Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the OPPS for hospital outpatient services designated by the Secretary (which includes partial hospitalization services furnished by community mental health centers (CMHCs)) and hospital outpatient services that are furnished to inpatients who have exhausted their Part A benefits or who are otherwise not in a covered Part A stay. Section 611 of Pub. L. 108–173 added provisions for Medicare coverage of an initial preventive physical examination, subject to the applicable deductible and coinsurance, as an outpatient department service, payable under the OPPS.

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

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

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

B. Excluded OPPS Services and Hospitals

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

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

C. Prior Rulemaking

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

Since initially implementing the OPPS, we have published final rules in the **Federal Register** annually to implement statutory requirements and changes arising from our experience with this system. We last published such a document on November 10, 2005 (70 FR 68516). In that final rule with comment period, we revised the OPPS to update the payment weights and conversion factor for services payable under the CY 2006 OPPS on the basis of claims data from January 1, 2004, through December 31, 2004, and to implement certain provisions of Pub. L. 108–173. In addition, we responded to public comments received on the provisions of November 15, 2004 final rule with comment period pertaining to the APC assignment of HCPCS codes identified in Addendum B of that rule with the new interim (NI) comment indicators; and public comments received on the July 25, 2005 OPPS proposed rule for CY 2006 (70 FR 42674).

We published a correction of the November 10, 2005 final rule with comment period on December 23, 2005 (70 FR 76176). This correction document corrected a number of technical errors that appeared in the November 10, 2005 final rule with comment period.

D. APC Advisory Panel

1. Authority of the APC Panel

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA, requires that we consult with an outside panel of experts to review the clinical integrity of the payment groups and their weights under the OPPS. The Act further specifies that the panel will act in an advisory capacity. The Advisory Panel on Ambulatory Payment

Classification (APC) Groups (the APC Panel), discussed under section I.D.2. of this preamble, fulfills these requirements. The APC Panel is not restricted to using data compiled by CMS and may use data collected or developed by organizations outside the Department in conducting its review.

2. Establishment of the APC Panel

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

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

3. APC Panel Meetings and Organizational Structure

The APC Panel first met on February 27, February 28, and March 1, 2001. Since that initial meeting, the APC Panel has held nine subsequent meetings, with the last meeting taking place on March 1 and 2, 2006. (The APC Panel did not meet on March 3, 2006, as announced in the meeting notice published on December 23, 2005 (70 FR 76313).) Prior to each meeting, we publish a notice in the **Federal Register** to announce the meeting and, when necessary, to solicit and announce nominations for APC Panel membership.

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

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

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

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

1. Reduction in Threshold for Separate APCs for Drugs

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

2. Special Payment for Brachytherapy

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

F. Provisions of the Deficit Reduction Act of 2005

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

1. 3-Year Transition of Hold Harmless Payments

Section 5105 of Pub. L. 109–171 provides a 3-year transition of hold harmless OPPS payments for hospitals located in a rural area with not more than 100 beds that are not defined as sole community hospitals (SCHs). This provision provides an increased payment for such hospitals for covered OPD services furnished on or after January 1, 2006, and before January 1, 2009, if the OPPS payment they receive is less than the pre-BBA payment amount that they would have received for the same covered OPD services. This provision specifies that, in such cases, the amount of payment to the specified hospitals shall be increased by the applicable percentage of such difference. Section 5105 specifies the applicable percentage as 95 percent for CY 2006, 90 percent for CY 2007, and 85 percent for CY 2008.

2. Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms

Section 5112 of Pub. L. 109–171 amended section 1861 of the Act to include coverage of ultrasound screening for abdominal aortic aneurysms for certain individuals on or after January 1, 2007. The provision will apply to individuals (a) Who receive a referral for such an ultrasound screening as a result of an initial preventive physical examination; (b) who have not

been previously furnished with an ultrasound screening under Medicare; and (c) who have a family history of abdominal aortic aneurysm or manifest risk factors included in a beneficiary category recommended for screening (as determined by the United States Preventive Services Task Force). Ultrasound screening for abdominal aortic aneurysm will be included in the initial preventive physical examination. Section 5112 also added ultrasound screening for abdominal aortic aneurysm to the list of services for which the beneficiary deductible does not apply. These amendments apply to services furnished on or after January 1, 2007.

G. Summary of the Major Content of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital OPPS for CY 2007. These changes would be effective for services furnished on or after January 1, 2007. We are setting forth proposed changes to the Medicare ASC program for CY 2007 and CY 2008. We are setting forth proposed changes to the way we process FFS claims under Medicare Part A and Part B. Some of these changes were effective on October 1, 2005 and all of the changes are to be fully implemented by October 1, 2011. Finally, we are setting forth a notice seeking comments on the RHQDAPU program under the Medicare hospital IPPS for FY 2008. These changes would be effective for payments beginning with FY 2008. The following is a summary of the major changes that we are proposing to make:

1. Proposed Updates Affecting Payments for CY 2007

In section II. of this preamble, we set forth—

- The methodology used to recalibrate the proposed APC relative payment weights and the proposed recalibration of the relative payment weights for CY 2007.
- The proposed payment for partial hospitalization, including the proposed separate threshold for outlier payments for CMHCs.
- The proposed update to the conversion factor used to determine payment rates under the OPPS for CY 2007.
- The proposed retention of our current policy to apply the IPPS wage indices to wage adjust the APC median costs in determining the OPPS payment rate and the copayment standardized amount for CY 2007.
- The proposed update of statewide average default cost-to-charge ratios.
- Proposed changes relating to the expiring hold harmless payment provision.
- Proposed changes to payment for rural sole community hospitals for CY 2007.
- Proposed changes in the way we calculate hospital outpatient outlier payments for CY 2007.
- Calculation of the proposed national unadjusted Medicare OPPS payment.
- The proposed beneficiary copayment for OPPS services for CY 2007.

2. Proposed Ambulatory Payment Classification (APC) Group Policies

In section III. of this preamble, we discuss the proposed additions of new procedure codes to the APCs; our proposal to establish a number of new APCs; and our proposal to make changes to the assignment of HCPCS codes under a number of existing APCs based on our analyses of Medicare claims data and recommendations of the APC Panel. We also discuss the application of the 2 times rule and proposed exceptions to it; proposed changes for specific APCs; the proposed refinement of the New Technology cost bands; and the proposed movement of procedures from the New Technology APCs.

3. Proposed Payment Changes for Devices

In section IV. of this preamble, we discuss proposed changes to the device-dependent APCs, and to the pass-through payment for categories of devices.

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

In section V. of this preamble, we discuss proposed changes for drugs, biologicals, and radiopharmaceuticals.

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

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

6. Proposed Brachytherapy Payment Changes

In section VII. of this preamble, we discuss our proposal concerning coding and payment for the sources of brachytherapy.

7. Proposed Coding and Payment for Drug and Vaccine Administration

In section VIII. of this preamble, we discuss our proposed coding and payment changes for drug and vaccine administration services.

8. Proposed Hospital Coding for Evaluation and Management (E/M) Services

In section IX. of this preamble, we discuss our proposal for developing the coding guidelines for evaluation and management services.

9. Proposed Payment for Blood and Blood Products

In section X. of this preamble, we discuss our proposed payment changes for blood and blood products.

10. Proposed Payment for Observation Services

In section XI. of this preamble, we discuss our proposed criteria and coding changes for separately payable observation services.

11. Procedures That Will Be Paid Only as Inpatient Services

In section XII. of this preamble, we discuss the procedures that we propose to remove from the inpatient list and assign to APCs.

12. Proposed Nonrecurring Policy Changes

In section XIII. of this preamble, we discuss proposed changes to certain comprehensive outpatient rehabilitation facility (CORF) services paid under the OPPS. In this section, we also discuss proposed payment for ultrasound screening for abdominal aortic aneurysms (AAAs).

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

In section XIV. of this preamble, we discuss proposed changes to a regulation governing emergency medical screening in critical access hospitals (CAHs).

14. Proposed OPPS Payment Status and Comment Indicator

In section XV. of this preamble, we discuss proposed changes to the list of status indicators assigned to APCs and present our proposed comment indicators for the CY 2007 OPPS final rule.

15. OPPS Policy and Payment Recommendations

In section XVI. of this preamble, we address recommendations made by MedPAC and the APC Panel regarding the OPPS for CY 2007.

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

In section XVII. of this preamble we discuss proposed payment changes affecting ASCs in CY 2007, the proposed list of updated ASC procedures, and proposed modification of the ASC payment adjustment process for new technology intraocular lenses (NTIOLs).

17. Proposed Revised Ambulatory Surgical Center (ASC) Payment System for Implementation January 1, 2008

In section XVIII. of this preamble, we discuss our proposal to implement a new ASC payment system for services furnished on or after January 1, 2008, and the regulatory changes related to the proposed new system.

18. Medicare Provider Contractor Reform Mandate

In section XIX. of this preamble, we discuss proposed changes to the regulations under 42 CFR Part 421, Subpart B to conform them to the statutory changes required by section 911 of Public Law 108–173 related to Medicare contracting reform.

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

In section XX. of this preamble, we discuss the expenditure growth in outpatient hospital services, invite comment on value-based purchasing specifically related to hospital outpatient departments, and discuss a value-based purchasing program proposal for the CY 2007 OPPS.

20. Promoting Effective Use of Health Information Technology

In section XXI. of this preamble, we invite comments on promoting hospitals' effective use of health information technology.

21. Health Care Information Transparency Initiative

In section XXII. of this preamble, we discuss HHS' major health information transparency initiative which we are launching in 2006.

22. Reporting Hospital Quality Data for Annual Payment Update Under the IPPS

In section XXIII. of this preamble, we invite comment on our proposal for the FY 2008 IPPS annual payment update to add the HCAHPS® survey, measures from the Surgical Care Improvement Project (SCIP), and Mortality measures to the quality of care measures to be used in FY 2007 for purposes of the IPPS annual payment update.

23. Impact Analysis

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

II. Proposed Updates Affecting OPPS Payments for CY 2007

A. Proposed Recalibration of APC Relative Weights for CY 2007

(If you choose to comment on the issues in this section, please include the caption ''APC Relative Weights'' at the beginning of your comment.)

1. Database Construction

a. Database Source and Methodology

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

We are proposing to use the same basic methodology that we described in the April 7, 2000 final rule with comment period to recalibrate the APC relative payment weights for services furnished on or after January 1, 2007, and before January 1, 2008. That is, we would recalibrate the relative payment weights for each APC based on claims and cost report data for outpatient services. We are proposing to use the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating APC relative payment weights in this proposed rule for CY 2007, we used approximately 131.9 million final action claims for hospital OPD services furnished on or after January 1, 2005, and before January 1, 2006. Of the 131.9 million final action claims for services provided in hospital outpatient settings, 102.9 million claims were of the type of bill potentially appropriate for use in setting rates for OPPS services (but did not necessarily contain services payable under the OPPS). Of the 102.9 million claims, approximately 48.5 million were not for services paid under the OPPS or were excluded as not appropriate for use (for example, erroneous cost-to-charge ratios or no HCPCS codes reported on the claim). We were able to use 50.7 million whole claims of the remaining 54.4 million claims to set the proposed OPPS APC relative weights for CY 2007 OPPS. From the 50.7 million whole claims, we created 91.4 million single records, of which 62.8 million were ''pseudo'' single claims (created from multiple procedure claims using the process we discuss in this section).

The proposed APC relative weights and payments for CY 2007 in Addenda A and B to this proposed rule were calculated using claims from this period that had been processed before January 1, 2006. 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 are proposing that the APC relative weights for CY 2007 continue to be based on the median hospital costs for services in the APC groups. For the CY 2007 OPPS final rule, we are proposing to base APC median costs on claims for services furnished in CY 2005 and processed before June 30, 2006.

b. Proposed Use of Single and Multiple Procedure Claims

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

We agree that, optimally, it is desirable to use the data from as many claims as possible to recalibrate the APC relative payment weights, including those with multiple procedures. We generally use single procedure claims to set the median costs for APCs because we are, so far, unable to ensure that packaged costs can be appropriately allocated across multiple procedures performed on the same date of service. However, by bypassing specified codes that we believe do not have significant packaged costs, we are able to use more data from multiple procedure claims. In many cases, this enables us to create multiple ''pseudo'' single claims from claims that, as submitted, contained

multiple separately paid procedures on the same claim. For the CY 2007 OPPS, we are proposing to use the date of service on the claims and a list of codes to be bypassed to create ''pseudo'' single claims from multiple procedure claims, as we did in recalibrating the CY 2006 APC relative payment weights. We refer to these newly created single procedure claims as ''pseudo'' single claims because they were submitted by providers as multiple procedure claims.

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

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

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

For CY 2006, we continued using the codes on the CY 2005 OPPS bypass list and expanded it to include 404 bypass codes, including 3 bladder catheterization codes (CPT codes 51701, 51702, and 51703), which did not meet the empirical criteria discussed below for the selection of bypass codes. We added these three codes to the CY 2006 bypass list because a decision to change their payment status from packaged to separately paid would have resulted in a reduction of the number of single bills on which we could base median costs for other major separately paid procedures that were billed on the same claim with these three procedure codes. That is, single bills which contained other procedures would have become multiple procedure claims when these bladder catheterization codes were converted to separately paid status. We believed and continue to believe that bypassing these three codes does not adversely affect the medians for other procedures because we believe that when these services are performed on the same day as another separately paid service, any packaging that appears on the claim would be appropriately associated with the other procedure and not with these codes.

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

For CY 2007, we are proposing to continue using date-of-service matching as a tool for creation of ''pseudo'' single claims and to continue the use of a bypass list to create ''pseudo'' single claims. The process we are proposing for CY 2007 OPPS results in our being able to use some part of 94.8 percent of the total claims that are eligible for use in the OPPS ratesetting and modeling in developing this proposed rule. This process enabled us to use, for CY 2007, 62.8 million ''pseudo'' singles and 29.6 million ''natural'' single bills.

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

To facilitate comment, Table 1 indicates the list of codes we are proposing to bypass for creation of ''pseudo'' singles for CY 2007 OPPS. Bypass codes shown in Table 1 with an asterisk indicate the HCPCS codes we are proposing to add to the CY 2006 OPPS listed codes for bypass in CY 2007. The criteria we are proposing to use to determine the additional codes to add to the CY 2006 OPPS bypass list in order to create the bypass list for CY 2007 OPPS are discussed below.

The following empirical criteria were developed by reviewing the frequency and magnitude of packaging in the single claims for payable codes other than drugs and biologicals. We assumed that the representation of packaging on the single claims for any given code is comparable to packaging for that code in the multiple claims:

- There were 100 or more single claims for the code. This number of single claims ensured that observed outcomes were sufficiently representative of packaging that might occur in the multiple claims.
- Five percent or fewer of the single claims for the code had packaged costs on that single claim for the code. This criterion results in limiting the amount of packaging being redistributed to the payable procedure remaining on the claim after the bypass code is removed and ensures that the costs associated with the bypass code represent the cost of the bypassed service.

- The median cost of packaging observed in the single claim was equal to or less than $50. This limits the amount of error in redistributed costs.
- The code is not a code for an unlisted service.

In addition, we are proposing to add to the bypass list codes that our clinicians believe contain minimal packaging and codes for specified drug administration for which hospitals have requested separate payment but for which it is not possible to acquire median costs unless we add these codes to the bypass list. A more complete discussion of the effects of adding these drug administration codes to the bypass list is contained in the discussion of drug administration in section VIII.C. of this preamble.

We specifically invite public comment on the ''pseudo'' single process, including the bypass list and the criteria.

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

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
11056	Trim skin lesions, 2 to 4	T	0012	
11057	Trim skin lesions, over 4	T	0013	
11719	Trim nail(s)	T	0009	
11720	Debride nail, 1-5	T	0009	
11721	Debride nail, 6 or more	T	0009	
17003	Destroy lesions, 2-14	T	0010	
31231	Nasal endoscopy, dx	T	0072	
31579	Diagnostic laryngoscopy	T	0073	
51701	Insert bladder catheter	X	0340	
51702	Insert temp bladder cath	X	0340	
51703	Insert bladder cath, complex	T	0164	
51798	Us urine capacity measure	X	0340	
54240	Penis study	T	0164	
67820	Revise eyelashes	S	0698	
70030	X-ray eye for foreign body	X	0260	
70100	X-ray exam of jaw	X	0260	
70110	X-ray exam of jaw	X	0260	
70130	X-ray exam of mastoids	X	0260	
70140	X-ray exam of facial bones	X	0260	
70150	X-ray exam of facial bones	X	0260	
70160	X-ray exam of nasal bones	X	0260	
70200	X-ray exam of eye sockets	X	0260	
70210	X-ray exam of sinuses	X	0260	
70220	X-ray exam of sinuses	X	0260	
70250	X-ray exam of skull	X	0260	
70260	X-ray exam of skull	X	0261	
70328	X-ray exam of jaw joint	X	0260	
70330	X-ray exam of jaw joints	X	0260	
70336	Magnetic image, jaw joint	S	0335	
70355	Panoramic x-ray of jaws	X	0260	
70360	X-ray exam of neck	X	0260	
70370	Throat x-ray & fluoroscopy	X	0272	
70371	Speech evaluation, complex	X	0272	
70450	Ct head/brain w/o dye	S	0332	
70480	Ct orbit/ear/fossa w/o dye	S	0332	
70486	Ct maxillofacial w/o dye	S	0332	
70544	Mr angiography head w/o dye	S	0336	
70551	Mri brain w/o dye	S	0336	
71010	Chest x-ray	X	0260	
71015	Chest x-ray	X	0260	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
71020	Chest x-ray	X	0260	
71021	Chest x-ray	X	0260	
71022	Chest x-ray	X	0260	
71023	Chest x-ray and fluoroscopy	X	0272	
71030	Chest x-ray	X	0260	
71034	Chest x-ray and fluoroscopy	X	0272	
71035	Chest x-ray	X	0260	N
71090	X-ray & pacemaker insertion	X	0272	
71100	X-ray exam of ribs	X	0260	
71101	X-ray exam of ribs/chest	X	0260	
71110	X-ray exam of ribs	X	0260	
71111	X-ray exam of ribs/chest	X	0261	
71120	X-ray exam of breastbone	X	0260	
71130	X-ray exam of breastbone	X	0260	
71250	Ct thorax w/o dye	S	0332	
72040	X-ray exam of neck spine	X	0260	
72050	X-ray exam of neck spine	X	0261	
72052	X-ray exam of neck spine	X	0261	
72069	X-ray exam of trunk spine	X	0260	
72070	X-ray exam of thoracic spine	X	0260	
72072	X-ray exam of thoracic spine	X	0260	
72074	X-ray exam of thoracic spine	X	0260	
72080	X-ray exam of trunk spine	X	0260	
72090	X-ray exam of trunk spine	X	0261	
72100	X-ray exam of lower spine	X	0260	
72110	X-ray exam of lower spine	X	0261	
72114	X-ray exam of lower spine	X	0261	
72120	X-ray exam of lower spine	X	0261	
72125	Ct neck spine w/o dye	S	0332	
72128	Ct chest spine w/o dye	S	0332	
72141	Mri neck spine w/o dye	S	0336	
72146	Mri chest spine w/o dye	S	0336	
72148	Mri lumbar spine w/o dye	S	0336	
72170	X-ray exam of pelvis	X	0260	
72190	X-ray exam of pelvis	X	0260	
72192	Ct pelvis w/o dye	S	0332	
72220	X-ray exam of tailbone	X	0260	
73000	X-ray exam of collar bone	X	0260	
73010	X-ray exam of shoulder blade	X	0260	
73020	X-ray exam of shoulder	X	0260	
73030	X-ray exam of shoulder	X	0260	

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HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
73050	X-ray exam of shoulders	X	0260	
73060	X-ray exam of humerus	X	0260	
73070	X-ray exam of elbow	X	0260	
73080	X-ray exam of elbow	X	0260	
73090	X-ray exam of forearm	X	0260	
73100	X-ray exam of wrist	X	0260	
73110	X-ray exam of wrist	X	0260	
73120	X-ray exam of hand	X	0260	
73130	X-ray exam of hand	X	0260	
73140	X-ray exam of finger(s)	X	0260	
73200	Ct upper extremity w/o dye	S	0332	N
73218	Mri upper extremity w/o dye	S	0336	
73221	Mri joint upr extrem w/o dye	S	0336	
73510	X-ray exam of hip	X	0260	
73520	X-ray exam of hips	X	0261	
73540	X-ray exam of pelvis & hips	X	0260	
73550	X-ray exam of thigh	X	0260	
73560	X-ray exam of knee, 1 or 2	X	0260	
73562	X-ray exam of knee, 3	X	0260	
73564	X-ray exam, knee, 4 or more	X	0260	
73565	X-ray exam of knees	X	0260	
73590	X-ray exam of lower leg	X	0260	
73600	X-ray exam of ankle	X	0260	
73610	X-ray exam of ankle	X	0260	
73620	X-ray exam of foot	X	0260	
73630	X-ray exam of foot	X	0260	
73650	X-ray exam of heel	X	0260	
73660	X-ray exam of toe(s)	X	0260	
73700	Ct lower extremity w/o dye	S	0332	
73718	Mri lower extremity w/o dye	S	0336	
73721	Mri jnt of lwr extre w/o dye	S	0336	
74000	X-ray exam of abdomen	X	0260	
74010	X-ray exam of abdomen	X	0260	
74150	Ct abdomen w/o dye	S	0332	N
74210	Contrst x-ray exam of throat	S	0276	
74220	Contrast x-ray, esophagus	S	0276	
74230	Cine/vid x-ray, throat/esoph	S	0276	
74235	Remove esophagus obstruction	S	0296	
74240	X-ray exam, upper gi tract	S	0276	
74245	X-ray exam, upper gi tract	S	0277	
74246	Contrst x-ray uppr gi tract	S	0276	

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HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
74247	Contrst x-ray uppr gi tract	S	0276	
74249	Contrst x-ray uppr gi tract	S	0277	
74250	X-ray exam of small bowel	S	0276	
74300	X-ray bile ducts/pancreas	X	0263	
74301	X-rays at surgery add-on	X	0263	
74305	X-ray bile ducts/pancreas	X	0263	
74327	X-ray bile stone removal	S	0296	
74340	X-ray guide for GI tube	X	0272	
74350	X-ray guide, stomach tube	X	0263	
74355	X-ray guide, intestinal tube	X	0263	
74360	X-ray guide, GI dilation	S	0296	
74363	X-ray, bile duct dilation	S	0297	
74475	X-ray control, cath insert	S	0297	
74480	X-ray control, cath insert	S	0296	
74485	X-ray guide, GU dilation	S	0296	
75894	X-rays, transcath therapy	S	0297	
75898	Follow-up angiography	X	0263	
75901	Remove cva device obstruct	X	0263	
75902	Remove cva lumen obstruct	X	0263	
75945	Intravascular us	S	0267	
75960	Transcath iv stent rs&i	S	0668	
75961	Retrieval, broken catheter	S	0668	
75962	Repair arterial blockage	S	0668	
75964	Repair artery blockage, each	S	0668	
75966	Repair arterial blockage	S	0668	
75968	Repair artery blockage, each	S	0668	
75970	Vascular biopsy	S	0668	
75978	Repair venous blockage	S	0668	
75980	Contrast xray exam bile duct	S	0297	
75982	Contrast xray exam bile duct	S	0297	
75984	Xray control catheter change	X	0263	
75992	Atherectomy, x-ray exam	S	0279	
75993	Atherectomy, x-ray exam	S	0279	
75994	Atherectomy, x-ray exam	S	0279	N
75995	Atherectomy, x-ray exam	S	0279	N
76012	Percut vertebroplasty fluor	S	0274	
76013	Percut vertebroplasty, ct	S	0274	
76040	X-rays, bone evaluation	X	0261	
76061	X-rays, bone survey	X	0261	
76062	X-rays, bone survey	X	0261	
76066	Joint survey, single view	X	0260	

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HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
76070	Ct bone density, axial	S	0288	
76071	Ct bone density, peripheral	S	0282	N
76075	Dxa bone density, axial	S	0288	
76076	Dxa bone density/peripheral	S	0665	
76077	Dxa bone density/v-fracture	X	0260	N
76078	Radiographic absorptiometry	X	0260	
76095	Stereotactic breast biopsy	X	0264	
76096	X-ray of needle wire, breast	X	0263	
76100	X-ray exam of body section	X	0261	
76101	Complex body section x-ray	X	0263	
76355	Ct scan for localization	S	0283	N
76360	Ct scan for needle biopsy	S	0283	
76362	Ct guide for tissue ablation	S	0333	N
76370	Ct scan for therapy guide	S	0282	N
76380	CAT scan follow-up study	S	0282	
76393	Mr guidance for needle place	S	0335	
76394	MRI for tissue ablation	S	0335	N
76511	Ophth us, quant a only	S	0266	
76512	Ophth us, b w/non-quant a	S	0266	
76513	Echo exam of eye, water bath	S	0266	N
76514	Echo exam of eye, thickness	X	0340	N
76516	Echo exam of eye	S	0265	
76519	Echo exam of eye	S	0266	
76536	Us exam of head and neck	S	0266	
76645	Us exam, breast(s)	S	0265	
76700	Us exam, abdom, complete	S	0266	
76705	Echo exam of abdomen	S	0266	
76770	Us exam abdo back wall, comp	S	0266	
76775	Us exam abdo back wall, lim	S	0266	
76778	Us exam kidney transplant	S	0266	
76801	Ob us < 14 wks, single fetus	S	0266	
76811	Ob us, detailed, sngl fetus	S	0267	
76816	Ob us, follow-up, per fetus	S	0265	N
76817	Transvaginal us, obstetric	S	0266	
76830	Transvaginal us, non-ob	S	0266	
76856	Us exam, pelvic, complete	S	0266	
76857	Us exam, pelvic, limited	S	0265	
76870	Us exam, scrotum	S	0266	
76880	Us exam, extremity	S	0266	
76930	Echo guide, cardiocentesis	S	0268	N
76932	Echo guide for heart biopsy	S	0268	N

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HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
76936	Echo guide for artery repair	S	0268	N
76940	Us guide, tissue ablation	S	0268	N
76941	Echo guide for transfusion	S	0268	N
76942	Echo guide for biopsy	S	0268	N
76945	Echo guide, villus sampling	S	0268	N
76946	Echo guide for amniocentesis	S	0268	
76948	Echo guide, ova aspiration	S	0268	N
76950	Echo guidance radiotherapy	S	0268	
76965	Echo guidance radiotherapy	S	0268	N
76970	Ultrasound exam follow-up	S	0265	
76975	GI endoscopic ultrasound	S	0266	N
76977	Us bone density measure	X	0340	
76986	Ultrasound guide intraoper	S	0266	N
77280	Set radiation therapy field	X	0304	
77285	Set radiation therapy field	X	0305	
77290	Set radiation therapy field	X	0305	N
77295	Set radiation therapy field	X	0310	
77300	Radiation therapy dose plan	X	0304	
77301	Radiotherapy dose plan, imrt	X	0310	
77315	Teletx isodose plan complex	X	0305	
77326	Brachytx isodose calc simp	X	0304	
77327	Brachytx isodose calc interm	X	0305	
77328	Brachytx isodose plan compl	X	0305	
77331	Special radiation dosimetry	X	0304	
77332	Radiation treatment aid(s)	X	0303	
77333	Radiation treatment aid(s)	X	0303	
77334	Radiation treatment aid(s)	X	0303	
77336	Radiation physics consult	X	0304	
77370	Radiation physics consult	X	0304	
77401	Radiation treatment delivery	S	0300	N
77402	Radiation treatment delivery	S	0300	
77403	Radiation treatment delivery	S	0300	
77404	Radiation treatment delivery	S	0300	
77407	Radiation treatment delivery	S	0300	N
77408	Radiation treatment delivery	S	0300	
77409	Radiation treatment delivery	S	0300	
77411	Radiation treatment delivery	S	0301	
77412	Radiation treatment delivery	S	0301	
77413	Radiation treatment delivery	S	0301	
77414	Radiation treatment delivery	S	0301	
77416	Radiation treatment delivery	S	0301	

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HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
77417	Radiology port film(s)	X	0260	
77418	Radiation tx delivery, imrt	S	0412	
77470	Special radiation treatment	S	0299	
78350	Bone mineral, single photon	X	0260	
80500	Lab pathology consultation	X	0433	N
80502	Lab pathology consultation	X	0342	
85060	Blood smear interpretation	X	0342	
86585	TB tine test	X	0341	
86850	RBC antibody screen	X	0345	
86870	RBC antibody identification	X	0346	
86880	Coombs test, direct	X	0409	
86885	Coombs test, indirect, qual	X	0409	
86886	Coombs test, indirect, titer	X	0409	
86890	Autologous blood process	X	0347	
86900	Blood typing, ABO	X	0409	
86901	Blood typing, Rh (D)	X	0409	
86905	Blood typing, RBC antigens	X	0345	
86906	Blood typing, Rh phenotype	X	0345	
86930	Frozen blood prep	X	0347	
86970	RBC pretreatment	X	0345	
88104	Cytopathology, fluids	X	0433	
88106	Cytopathology, fluids	X	0433	
88107	Cytopathology, fluids	X	0433	
88108	Cytopath, concentrate tech	X	0433	
88112	Cytopath, cell enhance tech	X	0343	N
88160	Cytopath smear, other source	X	0433	
88161	Cytopath smear, other source	X	0433	
88162	Cytopath smear, other source	X	0433	N
88172	Cytopathology eval of fna	X	0343	
88182	Cell marker study	X	0344	
88184	Flowcytometry/ tc, 1 marker	X	0344	N
88300	Surgical path, gross	X	0433	
88304	Tissue exam by pathologist	X	0343	
88305	Tissue exam by pathologist	X	0343	
88311	Decalcify tissue	X	0342	
88312	Special stains	X	0433	
88313	Special stains	X	0433	
88321	Microslide consultation	X	0433	
88323	Microslide consultation	X	0343	
88325	Comprehensive review of data	X	0344	
88331	Path consult intraop, 1 bloc	X	0343	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
88342	Immunohistochemistry	X	0343	
88346	Immunofluorescent study	X	0343	
88347	Immunofluorescent study	X	0343	
88348	Electron microscopy	X	0661	N
88358	Analysis, tumor	X	0344	N
88360	Tumor immunohistochem/manual	X	0344	N
88365	Insitu hybridization (fish)	X	0344	N
88368	Insitu hybridization, manual	X	0344	N
90781	drug admin subs hour	S	0438	N
90801	Psy dx interview	S	0323	
90804	Psytx, office, 20-30 min	S	0322	
90805	Psytx, off, 20-30 min w/e&m	S	0322	
90806	Psytx, off, 45-50 min	S	0323	
90807	Psytx, off, 45-50 min w/e&m	S	0323	
90808	Psytx, office, 75-80 min	S	0323	
90809	Psytx, off, 75-80, w/e&m	S	0323	
90810	Intac psytx, off, 20-30 min	S	0322	
90818	Psytx, hosp, 45-50 min	S	0323	
90826	Intac psytx, hosp, 45-50 min	S	0323	
90845	Psychoanalysis	S	0323	
90846	Family psytx w/o patient	S	0324	
90847	Family psytx w/patient	S	0324	
90853	Group psychotherapy	S	0325	
90857	Intac group psytx	S	0325	
90862	Medication management	X	0374	
92002	Eye exam, new patient	V	0601	
92004	Eye exam, new patient	V	0602	
92012	Eye exam established pat	V	0600	
92014	Eye exam & treatment	V	0601	
92020	Special eye evaluation	S	0230	
92081	Visual field examination(s)	S	0230	
92082	Visual field examination(s)	S	0230	
92083	Visual field examination(s)	S	0230	
92135	Opthalmic dx imaging	S	0230	
92136	Ophthalmic biometry	S	0698	
92225	Special eye exam, initial	S	0230	
92226	Special eye exam, subsequent	S	0230	
92230	Eye exam with photos	T	0699	
92240	Icg angiography	S	0231	N
92250	Eye exam with photos	S	0230	
92275	Electroretinography	S	0231	

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HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
92285	Eye photography	S	0230	
92286	Internal eye photography	S	0698	
92520	Laryngeal function studies	X	0660	
92541	Spontaneous nystagmus test	X	0363	
92546	Sinusoidal rotational test	X	0660	
92548	Posturography	X	0660	
92552	Pure tone audiometry, air	X	0364	
92553	Audiometry, air & bone	X	0365	
92555	Speech threshold audiometry	X	0364	
92556	Speech audiometry, complete	X	0364	
92557	Comprehensive hearing test	X	0365	
92567	Tympanometry	X	0364	
92582	Conditioning play audiometry	X	0365	
92585	Auditor evoke potent, compre	S	0216	
92604	Reprogram cochlear implt 7 >	X	0366	
93005	Electrocardiogram, tracing	S	0099	
93225	ECG monitor/record, 24 hrs	X	0097	
93226	ECG monitor/report, 24 hrs	X	0097	
93231	Ecg monitor/record, 24 hrs	X	0097	
93232	ECG monitor/report, 24 hrs	X	0097	
93236	ECG monitor/report, 24 hrs	X	0097	
93270	ECG recording	X	0097	
93271	Ecg/monitoring and analysis	X	0097	N
93278	ECG/signal-averaged	S	0099	
93303	Echo transthoracic	S	0269	
93307	Echo exam of heart	S	0269	
93320	Doppler echo exam, heart	S	0671	
93325	Doppler color flow add-on	S	0697	N
93731	Analyze pacemaker system	S	0690	
93732	Analyze pacemaker system	S	0690	
93733	Telephone analy, pacemaker	S	0690	
93734	Analyze pacemaker system	S	0690	
93735	Analyze pacemaker system	S	0690	
93736	Telephonic analy, pacemaker	S	0690	
93741	Analyze ht pace device sngl	S	0689	
93742	Analyze ht pace device sngl	S	0689	N
93743	Analyze ht pace device dual	S	0689	
93744	Analyze ht pace device dual	S	0689	N
93786	Ambulatory BP recording	X	0097	N
93788	Ambulatory BP analysis	X	0097	N
93797	Cardiac rehab	S	0095	

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HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
93798	Cardiac rehab/monitor	S	0095	
93875	Extracranial study	S	0096	
93880	Extracranial study	S	0267	
93882	Extracranial study	S	0267	
93886	Intracranial study	S	0267	
93888	Intracranial study	S	0266	
93922	Extremity study	S	0096	
93923	Extremity study	S	0096	
93924	Extremity study	S	0096	
93925	Lower extremity study	S	0267	
93926	Lower extremity study	S	0266	
93930	Upper extremity study	S	0267	
93931	Upper extremity study	S	0266	
93965	Extremity study	S	0096	
93970	Extremity study	S	0267	
93971	Extremity study	S	0266	
93975	Vascular study	S	0267	
93976	Vascular study	S	0267	
93978	Vascular study	S	0266	
93979	Vascular study	S	0266	
93990	Doppler flow testing	S	0266	
94015	Patient recorded spirometry	X	0367	
94681	Exhaled air analysis, o2/co2	X	0368	N
95115	Immunotherapy, one injection	X	0352	
95117	Immunotherapy injections	X	0353	
95165	Antigen therapy services	X	0353	
95805	Multiple sleep latency test	S	0209	
95806	Sleep study, unattended	S	0213	
95807	Sleep study, attended	S	0209	
95812	Eeg, 41-60 minutes	S	0213	
95813	Eeg, over 1 hour	S	0213	
95816	Eeg, awake and drowsy	S	0213	
95819	Eeg, awake and asleep	S	0213	
95822	Eeg, coma or sleep only	S	0213	
95864	Muscle test, 4 limbs	S	0218	
95867	Muscle test cran nerv unilat	S	0218	
95872	Muscle test, one fiber	S	0218	
95900	Motor nerve conduction test	S	0215	
95921	Autonomic nerv function test	S	0218	
95925	Somatosensory testing	S	0216	
95926	Somatosensory testing	S	0216	

HCPCS Code	Short Descriptor	Status Indicator	APC	Bypass Indicator*
95930	Visual evoked potential test	S	0216	
95937	Neuromuscular junction test	S	0218	
95950	Ambulatory eeg monitoring	S	0209	
95953	EEG monitoring/computer	S	0209	
95957	EEG digital analysis	S	0214	N
95970	Analyze neurostim, no prog	S	0218	
95972	Analyze neurostim, complex	S	0692	
95974	Cranial neurostim, complex	S	0692	
95978	Analyze neurostim brain/1h	S	0692	N
96000	Motion analysis, video/3d	S	0216	
96100	Psychological testing	X	0382	
96115	Neurobehavior status exam	X	0373	
96117	Neuropsych test battery	X	0382	
96150	Assess hlth/behave, init	S	0432	N
96151	Assess hlth/behave, subseq	S	0432	N
96152	Intervene hlth/behave, indiv	S	0432	N
96412	drug admin subs hour	S	0439	N
96423	drug admin subs hour	S	0439	N
96900	Ultraviolet light therapy	S	0001	
96910	Photochemotherapy with UV-B	S	0001	
96912	Photochemotherapy with UV-A	S	0001	
96913	Photochemotherapy, UV-A or B	S	0683	
98925	Osteopathic manipulation	S	0060	
98926	Osteopathic manipulation	S	0060	N
98940	Chiropractic manipulation	S	0060	
98941	Chiropractic manipulation	S	0060	N
99212	Office/outpatient visit, est	V	0600	N
99213	Office/outpatient visit, est	V	0601	
99214	Office/outpatient visit, est	V	0602	
99241	Office consultation	V	0600	
99242	Office consultation	V	0600	
99243	Office consultation	V	0601	
99244	Office consultation	V	0602	
99245	Office consultation	V	0602	
99272	Confirmatory consultation	V	0600	N
99273	Confirmatory consultation	V	0601	
99274	Confirmatory consultation	V	0602	
99275	Confirmatory consultation	V	0602	
G0101	CA screen;pelvic/breast exam	V	0600	
G0127	Trim nail(s)	T	0009	
G0130	Single energy x-ray study	X	0260	N
G0166	Extrnl counterpulse, per tx	T	0678	
G0175	OPPS Service,sched team conf	V	0602	
G0344	Initial preventive exam	V	0601	N
Q0091	Obtaining screen pap smear	T	0191	

*Bypass indicator "N" equals new

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c. Proposed Revision to the Overall Cost-to-Charge Ratio (CCR) Calculation

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

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

CMS' ''traditional'' calculation consists of summing the total costs from Worksheet B, Part I (Column 27), after removing the costs for nursing and paramedical education (Columns 21 and 24), for those ancillary cost centers that we believe contain most OPPS services, summing the total charges from Worksheet C, Part I (Columns 6 and 7) for the same set of ancillary cost centers, and dividing the former by the later. We exclude selected ancillary cost centers from our overall CCR calculation, such as 5700 Renal Dialysis, because we believe that the costs and charges in these cost centers are largely paid for under other payment systems. The specific list of ancillary cost centers, both standard and nonstandard, included in our overall CCR calculation is available on our Web site in the revenue center-to-cost center crosswalk workbook: *http://www.cms.hhs.gov/HospitalOutpatientPPS*.

The overall CCR calculation provided in Program Transmittal A–03–04, on the other hand, takes the CCRs from Worksheet C, Part I, Column 9, for each specified ancillary cost center; multiplies them by the Medicare Part B outpatient specific charges in each corresponding ancillary cost center from Worksheet D, Parts V and VI (Columns 2, 3, 4, and 5 and subscripts thereof); and then divides the sum of these costs by the sum of charges for the specified ancillary cost centers from Worksheet D, Parts V and VI (Columns 2, 3, 4, and 5 and subscripts thereof). Compared with our ''traditional'' overall CCR calculation that has been used for modeling OPPS and to calculate the median costs, this fiscal intermediary calculation of overall CCR fails to remove allied health costs and adds weighting by Medicare Part B charges.

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

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

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

In order to isolate the overall impact of adopting this methodology on APC medians, we used the first 9 months of CY 2005 claims data to estimate APC median costs varying only the two methods of determining overall CCR. We expected the impact to be limited because the majority of costs are estimated using a cost center-specific CCR and not the overall. As predicted, we observed minor changes in APC median costs from the adoption of the proposed overall CCR calculation. We largely observed differences of no more than 5 percent in either direction. The median overall percent change in APC cost estimates was -0.3 percent. We typically observe comparable changes in APC medians when we update our cost report data. The impact of the proposed CCR calculation on the outlier threshold is discussed further in section II. G. of this preamble. Using updated cost report data for the calculations in this proposed rule, we estimate a median overall CCR across all hospitals of 0.2999 using the proposed overall CCR calculation.

We believe that a single overall CCR calculation should be used for all components of the OPPS for both modeling and payment. Therefore, we are proposing to use the modified overall CCR calculation as discussed above when the hospital-specific overall CCR is used for any of the following calculations—in the CMS calculation of median costs for OPPS ratesetting, in the CMS calculation of the outlier threshold, in the fiscal intermediary calculation of outlier payments, in the CMS calculation of statewide CCRs, in the fiscal intermediary calculation of pass-through payments for devices, and for any other fiscal intermediary payment calculation in which the current hospital-specific overall CCR may be used now or in the future. If this proposal is finalized, we would issue a Medicare program instruction to fiscal intermediaries that would instruct them to recalculate and use the hospital-specific overall CCR as we are proposing for these purposes.

2. Proposed Calculation of Median Costs for CY 2007

In this section of the preamble, we discuss the use of claims to calculate the proposed OPPS payment rates for CY 2007. The hospital outpatient prospective payment page on the CMS Web site on which this proposed rule is posted provides an accounting of claims used in the development of the proposed rates: *http://www.cms.hhs.gov/HospitalOutpatientPPS.* The accounting of claims used in the development of this proposed rule is included on the Web site under supplemental materials for the CY 2007 proposed rule. That accounting provides additional detail regarding the number of claims derived at each stage of the process. In addition, below we discuss the files of claims that comprise the data sets that are available for purchase under a CMS data user contract. Our CMS Web site, *http://www.cms.hhs.gov/HospitalOutpatientPPS*, includes information about purchasing the following two OPPS data files: ''OPPS Limited Data Set'' and ''OPPS Identifiable Data Set.''

We are proposing to use the following methodology to establish the relative weights to be used in calculating the proposed OPPS payment rates for CY 2007 shown in Addenda A and B to this proposed rule. This methodology is as follows:

We used outpatient claims for the full CY 2005, processed before January 1, 2006, to set the relative weights for this proposed rule for CY 2007. To begin the calculation of the relative weights for CY 2007, we pulled all claims for outpatient services furnished in CY 2005 from the national claims history file. This is not the population of claims paid under the OPPS, but all outpatient claims (including, for example, CAH claims, and hospital claims for clinical laboratory services for persons who are neither inpatients nor outpatients of the hospital).

We then excluded claims with condition codes 04, 20, 21, and 77. These are claims that providers submitted to Medicare knowing that no payment will be made. For example, providers submit claims with a condition code 21 to elicit an official denial notice from Medicare and document that a service is not covered. We then excluded claims for services furnished in Maryland, Guam, and the U.S. Virgin Islands 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 103 million claims that contain hospital bill types paid under the OPPS.

1. Claims that were not bill types 12X, 13X, 14X (hospital bill types), or 76X (CMHC bill types). Other bill types are not paid under the OPPS and, therefore, these claims were not used to set OPPS payment.

2. Claims that were bill types 12X, 13X, or 14X (hospital bill types). These claims are hospital outpatient claims.

3. Claims that were bill type 76X (CMHC). (These claims are later combined with any claims in item 2 above with a condition code 41 to set the per diem partial hospitalization rate determined through a separate process.)

For the CCR calculation process, we used the same general approach as we used in developing the final APC rates for CY 2006 (70 FR 68537), with a change to the development of the overall CCR as discussed above. That is, we first limited the population of cost reports to only those for hospitals that filed outpatient claims in CY 2005 before determining whether the CCRs for such hospitals were valid.

We then calculated the CCRs at a cost center level and overall for each hospital for which we had claims data. We did this using hospital-specific data from the Healthcare Cost Report Information System (HCRIS). We used the most recent available cost report data, in most cases, cost reports for CY 2004. For this proposed rule, we used the most recent cost report available, whether submitted or settled. If the most recent available cost report was submitted but not settled, we looked at the last settled cost report to determine the ratio of submitted to settled cost using the overall CCR, and we then adjusted the most recent available submitted but not settled cost report using that ratio. We are proposing to use the most recently submitted cost reports to calculate the CCRs to be used to calculate median costs for the OPPS CY 2007 final rule. We calculated both an overall CCR and cost center-specific CCRs for each hospital. We used the proposed overall CCR calculation discussed in II.A.1.c. of this preamble for all purposes.

We then flagged CAH claims, which are not paid under the OPPS, and claims from hospitals with invalid CCRs. The latter included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from hospitals with obviously erroneous CCRs (greater than 90 or less than .0001); and those from hospitals with CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs). In addition, we trimmed the CCRs at the cost center level by removing the CCRs for each cost center as outliers if they exceeded +/-3 standard deviations from the geometric mean. This is the same methodology that we used in developing the final CY 2006 CCRs. For CY 2007, we are proposing to trim at the departmental CCR level to eliminate aberrant CCRs that, if found in high volume hospitals, could skew the medians. We used a four-tiered hierarchy of cost center CCRs to match a cost center to every possible revenue code appearing in the outpatient claims, with the top tier being the most common cost center and the last tier being the default CCR. If a hospital's cost center CCR was deleted by trimming, we set the CCR for that cost center to ''missing,'' so that another cost center CCR in the revenue center hierarchy could apply. If no other departmental CCR could apply to the revenue code on the claim, we used the hospital's overall CCR for the revenue code in question. For example, a visit reported under the clinic revenue code, but the hospital did not have a clinic cost center, we mapped the hospital-specific overall CCR to the clinic revenue code. The hierarchy of CCRs is available for inspection and comment at the CMS Web site: *http://www.cms.hhs.gov/HospitalOutpatientPPS.*

We then converted the charges to costs on each claim by applying the CCR that we believed was best suited to the revenue code indicated on the line with the charge. Table 2 below contains a list of the allowed revenue codes. Revenue codes not included in Table 2 are those

not allowed under the OPPS because their services cannot be paid under the OPPS (for example, inpatient room and board charges) and, thus charges with those revenue codes were not packaged for creation of the OPPS median costs. One exception is the calculation of median blood costs, as discussed in section X. of this preamble.

Thus, we applied CCRs as described above to claims with bill types 12X, 13X, or 14X, excluding all claims from CAHs and hospitals in Maryland, Guam, and the U.S. Virgin Islands, and claims from all hospitals for which CCRs were flagged as invalid.

We identified claims with condition code 41 as partial hospitalization services of hospitals and moved them to another file. These claims were combined with the 76X claims identified previously to calculate the partial hospitalization per diem rate.

We then excluded claims without a HCPCS code. We also moved claims for observation services to another file. We moved to another file claims that contained nothing but flu and pneumococcal pneumonia (''PPV'') vaccine. Influenza and PPV vaccines are paid at reasonable cost and, therefore, these claims are not used to set OPPS rates. We note that the two above mentioned separate files containing partial hospitalization claims and the observation services claims are included in the files that are available for purchase as discussed above.

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

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

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

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

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

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

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

In previous years, we made a determination of whether each HCPCS code was a major code, or a minor code, or a code other than a major or minor code. We used those code specific determinations to sort claims into these five identified groups. For CY 2007 OPPS, we are proposing to use status indicators, as described above, to sort the claims into these groups. We believe that using status indicators is an appropriate way to sort the claims into these groups and also to make our process more transparent to the public. We further believe that this proposed method of sorting claims will enhance the public's ability to derive useful information and become a more informed commenter on this proposed rule.

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

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

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

We also removed lines that contained multiple units of codes on the bypass list and treated them as ''pseudo'' single claims by dividing the cost for the multiple units by the number of units on the line. Where one unit of a single separately paid procedure code remained on the claim after removal of the multiple units of the bypass code, we created a ''pseudo'' single claim from that residual claim record, which retained the costs of packaged revenue codes and packaged HCPCS codes. This enables us to use claims that would otherwise be multiple procedure claims and could not be used. We excluded those claims that we were not able to convert to singles even after applying all of the techniques for creation of ''pseudo'' singles.

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

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, 97.5 million claims were left. Of these 97.5 million claims, we were able to use some portion of 50.7 million whole claims (93.2 percent of the 54.4 million potentially usable claims) to create the 91.4 million single and ''pseudo'' single claims for use in the CY 2007 median payment ratesetting. Approximately 43 million claims were for services not paid under the OPPS.

We also excluded (1) Claims that had zero costs after summing all costs on the claim and (2) claims containing payment flag 3. Effective for services furnished on or after July 1, 2004, the Outpatient Code Editor (OCE) assigns payment flag number 3 to claims on which hospitals submitted token charges for a service with status indicator ''S'' or ''T'' (a major separately paid service under OPPS) for which the fiscal intermediary is required to allocate the sum of charges for services with a status indicator equaling ''S'' or ''T'' based on the weight for the APC to which each code is assigned. We do not believe that these charges, which were token charges as submitted by the

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

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

We also excluded claims that were outside 3 standard deviations from the geometric mean of units for each HCPCS code on the bypass list (because, as discussed above, we used claims that contain multiple units of the bypass codes). We then deleted 299,022 single bills reported with modifier 50 that were assigned to APCs that contained HCPCS codes that are considered to be conditional or independent bilateral procedures under the OPPS and that are subject to special payment provisions implemented through the OCE. Modifier 50 signifies that the procedure was performed bilaterally. Although these are apparently single claims for a separately payable service and although there is only one unit of the code reported on the claim, the presence of modifier 50 signifies that two services were furnished. Therefore, costs reported on these claims are for two procedures and not for a single procedure. Hence, we deleted these multiple procedure records, which we would have treated as single procedure claims in prior OPPS updates. We are seeking comments on the relative benefits of deleting these claims versus dividing the costs for the two procedures by two to create two ''pseudo'' single claims.

We used the remaining claims to calculate median costs for each separately payable HCPCS code and each APC. The comparison of HCPCS and APC medians determines the applicability of the ''2 times'' rule. As stated previously, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (''the 2 times rule''). Finally, we reviewed the medians and reassigned HCPCS codes to different APCs as deemed appropriate. Section III.B. of this preamble includes a discussion of the HCPCS code assignment changes that resulted from examination of the medians and for other reasons. The APC medians were recalculated after we reassigned the affected HCPCS codes. Both the HCPCS medians and the APC medians were weighted to account for the inclusion of multiple units of the bypass codes in the creation of pseudo single bills.

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

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Table 2.--CY 2007 Proposed Packaged Services by Revenue Code

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

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3. Proposed Calculation of Scaled OPPS Payment Weights

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

For CY 2007 OPPS, we are proposing to scale all of the relative payment weights to APC 0606 (Level III Clinic Visits) because we are proposing to delete APC 0601 as part of the reconfiguration of the visit APCs. We chose APC 0606 as the scaling base because under our proposal to reconfigure the APCs where clinic visits are assigned for CY 2007, APC 0606 is the middle level clinic visit APC (that is, Level III of five levels). We have historically used the median cost of the middle level clinic visit APC (that is APC 0601 through CY 2006) to calculate unscaled weights because mid-level clinic visits are among the most frequently performed services in the hospital outpatient setting. Therefore, to maintain consistency in using as a median the most frequently used services, we are proposing to continue to use the median cost of the middle clinic level, proposed ASC 0606, to calculate unscaled weights. Following our standard methodology, but using the proposed CY 2007 median for APC 0606, we assigned APC 0606 a relative payment weight of 1.00 and divided the median cost of each APC by the median cost for APC 0606 to derive the unscaled relative payment weight for each APC. The choice of the APC on which to base the relative weights for all other APCs does not affect the payments made under the OPPS because we scale the weights for budget neutrality.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a manner that assures that aggregate payments under the OPPS for CY 2007 are neither greater than nor less than the aggregate payments that would have been made without the changes. To comply with this requirement concerning the APC changes, we compared aggregate payments using the CY 2006 relative weights to aggregate payments using the CY 2007 proposed relative payment weights. Based on this comparison, we adjusted the relative weights for purposes of budget neutrality. The unscaled relative payment weights were adjusted by 1.354626473 for budget neutrality. We recognize the scaler, or weight scaling factor, for budget neutrality that we are proposing for CY 2007 is higher than any previous OPPS weight scaler as a result of our proposal to use APC 0606 as the base for calculation of relative weights. Our proposed use of the median cost for APC 0606 of $83.67 causes the unscaled weights to be lower than they would have been if we had chosen APC 0605 (Level 2 Clinic Visits; median $62.12) as the scaling base. The CY 2007 median cost of APC 0606 is significantly higher than the CY 2006 median cost of APC 0601 for mid-level clinic visits, which was used in CY 2006 and earlier years to calculate unscaled weights. Historically, the median cost for APC 0601 has been similar to the CY 2007 proposed median cost for APC 0605. In order to appropriately scale the total weight estimated for OPPS in CY 2007 to be similar to the total weight in OPPS for CY 2006, we calculated a scaler of 1.354626473, which is higher using APC 0606 as the base than it would be if we used APC 0605 as the base. In addition to adjusting for increases and decreases in weight due the recalibration of APC medians, the scaler also accounts for any change in the base.

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

Section 1833(t)(14)(H) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, states that ''Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion factor, weighting and other adjustment factors for 2004 and 2005 under paragraph (9) but shall be taken into account for subsequent years.'' Section 1833(t)(14) of the Act provides the payment rates for certain ''specified covered outpatient drugs.'' Therefore, the cost of those specified covered outpatient drugs (as discussed in section V. of this preamble) is now included in the budget neutrality calculations for CY 2007 OPPS.

Under section 1833(t)(16)(C) of the Act, as added by section 621(b)(1) of Pub. L. 108–173, payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) is to be made at charges adjusted to cost for services furnished on or after January 1, 2004, and before January 1, 2007. As we stated in our January 6, 2004 interim final rule, charges for the brachytherapy sources were not used in determining outlier payments, and payments for these items were excluded from budget neutrality calculations for the CY 2006 OPPS. We excluded these payments from budget neutrality calculations, in part, because of the challenge posed by estimating hospital-specific cost payment. For CY 2007, we are proposing a specific payment rate for brachytherapy sources, which will be subject to scaling for budget neutrality. (We provide a discussion of brachytherapy payment issues, including their continued exclusion from outlier payments, under section VII. of this preamble.) Therefore, the costs of brachytherapy sources are accounted for in the scaler of 1.354626473.

4. Proposed Changes to Packaged Services

(If you choose to comment on the issues in this section, please include the caption ''Packaged Services'' at the beginning of your comment.)

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

As a result of requests from the public, a Packaging Subcommittee to the APC Panel was established to review all the procedural CPT codes with a status indicator of ''N.'' Providers have often suggested that many packaged services could be provided alone, without any other separately payable services on the claim, and requested that these codes not be assigned status indicator ''N.'' In deciding whether to package a service or pay for a code separately, we consider a variety of factors, including whether the service is normally provided separately or in conjunction with other services; how likely it is for the costs of the packaged code to be appropriately mapped to the separately payable codes

with which it was performed; and whether the expected cost of the service is relatively low.

The Packaging Subcommittee identified areas for change for some packaged CPT codes that it believed could frequently be provided to patients as the sole service on a given date and that required significant hospital resources as determined from hospital claims data.

Based on the comments received, additional issues, and new data that we shared with the Packaging Subcommittee concerning the packaging status of codes for CY 2007, the Packaging Subcommittee reviewed the packaging status of numerous HCPCS codes and reported its findings to the APC Panel at its March 2006 meeting. The APC Panel accepted the report of the Packaging Subcommittee, heard several presentations on certain packaged services, discussed the deliberations of the Packaging Subcommittee, and recommended that—

- CMS pay separately for HCPCS code 0069T (Acoustic heart sound recording and computer analysis only).
- CMS maintain the packaged status of HCPCS code 0152T (Computer aided detection with further physician review for interpretation, with or without digitization of films radiographic images; chest radiograph(s)).
- CMS maintain the packaged status of CPT code 36500 (venous catheterization for selective blood organ sampling).
- CMS pay separately for CPT code 36540 (Collect blood, venous access device) if there are no separately payable OPPS services on the claim.
- CMS pay separately for CPT code 36600 (Arterial puncture; withdrawal of blood for diagnosis) if there are no separately payable OPPS services on the claim.
- CMS pay separately for CPT code 38792 (Sentinel node identification) if there are no separately payable OPPS services on the claim.
- CMS maintain the packaged status of CPT codes 74328 (Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation), 74329 (Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation), and 74330 (Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation).
- CMS pay separately for CPT code 75893 (Venous sampling through catheter, with or without angiography, radiological supervision and interpretation) if there are no separately payable OPPS services on the claim.
- CMS continue to separately pay for CPT code 76000 (Fluoroscopy, up to one hour physician time).
- CMS maintain the packaged status of CPT codes 76001 (Fluoroscopy, physician time more than one hour), 76003 ((Fluoroscopic guidance for needle placement), and 76005 (Fluoroscopic guidance and localization of needle or catheter tip).
- CMS maintain the packaged status of CPT codes 76937 (Ultrasound guidance for vascular access) and 75998 (Fluoroscopic guidance for central venous access device placement, replacement, or removal).
- CMS provide separate payment for CPT codes 94760 (Noninvasive ear or pulse oximetry for oxygen saturation; single determination), 94761 (Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations), and 94762 (Noninvasive ear or pulse oximetry for oxygen saturation by continuous overnight monitoring) if there are no separately payable OPPS services on the claim.
- CMS pay separately for CPT code 96523 (Irrigation of implanted venous access device) if there are no separately payable OPPS services on the claim.
- CMS maintain the packaged status of HCPCS code G0269 (Placement of occlusive device into either a venous or arterial access site).
- CMS pay separately for HCPCS code P9612 (Catheterization for collection of specimen, single patient) if there are no separately payable OPPS services on the claim.
- CMS bring data to the next APC Panel meeting that show the following: (a) how the costs of packaged items and services are incorporated into the median costs of APCs and (b) how the costs of these packaged items and services influence payments for associated procedures.
- The Packaging Subcommittee continue until the next APC Panel meeting.

For CY 2007, we are proposing to maintain CPT code 0069T as a packaged service and not adopt the APC Panel's recommendation to pay separately for this code. The service uses signal processing technology to detect, interpret, and document acoustical activities of the heart through special sensors applied to a patient's chest. This code was a new Category III CPT code implemented in the CY 2005 OPPS and assigned a new interim status indicator of ''N'' in the CY 2005 OPPS final rule. The APC Panel recommended packaging CPT code 0069T for CY 2006, and we accepted that recommendation when we finalized the status indicator ''N'' assignment to 0069T for CY 2006. This code is indicated as an add-on code to an electrocardiography service, according to the AMA's CY 2006 CPT book. In its presentation to the APC Panel, the manufacturer requested that we pay separately for CPT code 0069T and assign it to APC 0099 (Electrocardiograms), based on its estimated cost and clinical characteristics.

At the APC Panel meeting, the manufacturer stated that the acoustic heart sounds recording and analysis service may be provided with or without a separately reportable electrocardiogram. Members of the APC Panel engaged in extensive discussion of clinical scenarios as they considered whether CPT code 0069T could or could not be appropriately reported alone or in conjunction with several different procedure codes. We note that the parenthetical information following the AMA's code descriptor indicates that CPT code 0069T is to be reported in conjunction with CPT code 93005 (Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report). In addition, we do not believe that, based on its expected clinical uses as described by the manufacturer, CPT code 0069T would ever be performed as a sole service without other separately payable OPPS services and payment for CPT code 0069T could always be packaged into payments for those other services. Therefore, we believe that CPT code 0069T is appropriately packaged because it is closely linked to the performance of an ECG, should never be reported alone, and is estimated to require only modest hospital resources. Using CY 2005 claims, we had only 9 single claims for CPT code 0069T, with a median line-item cost of $1.93, consistent with its low expected cost. Packaging payment for CPT code 0069T is consistent with the principles of a prospective payment system that provides payments for groups of services. To the extent that the acoustic heart sounding recording service may be more frequently provided in the future in association with ECGs or other OPPS services as its clinical indications evolve, we expect that its cost would also be increasingly reflected in the median costs for those other services, particularly ECG procedures.

For CY 2007, we are proposing to accept the APC Panel's recommendation to maintain the packaged status of CPT code 0152T. The service involves the application of computer algorithms and classification technologies to chest x-ray

images to acquire and display information regarding chest x-ray regions that may contain indications of cancer. This code was a new Category III CPT code implemented in the CY 2006 OPPS and assigned a new interim status indicator of ''N'' in the CY 2006 OPPS final rule with comment period. The code is indicated as an add-on code to chest x-ray CPT codes, according to the AMA's CY 2006 CPT book. In its presentation to the APC Panel, the manufacturer requested that we pay separately for this service and assign it to a New Technology APC with a payment rate of $15, based on its estimated cost, clinical considerations, and similarity to other image post-processing services that are paid separately.

Under the OPPS we make payment for medically necessary services either separately or packaged into our payments for other services. We agree with the APC Panel that packaged payment for diagnostic chest x-ray computer-aided detection (CAD) under a prospective payment methodology for outpatient hospital services is appropriate because of the close relationship of chest x-ray CAD to chest x-ray services and its projected modest cost. Because 0152T is a new CPT code for CY 2006, we have no CY 2005 hospital claims data available for analysis. To the extent that CAD may be more frequently provided in the future to aid in the review of diagnostic chest x-rays as its clinical indications evolve, we expect that its cost would also be increasingly reflected in the median costs for chest x-ray procedures.

For CY 2007, we are proposing to accept the recommendation of the APC Panel and maintain the packaged status of CPT code 36500. We note that several providers have commented that CPT code 36500 is sometimes billed only with its corresponding radiological supervision and interpretation code, 75893, but with no other separately payable OPPS services. In those cases, the provider would not receive any payment. For CY 2006, we accepted the APC Panel's recommendation to package both CPT codes 36500 and 75893 and to examine claims data. Our initial review of several clinical scenarios submitted by the public seemed to suggest that other separately payable procedures, such as venography, would likely be billed on the same claim. Our claims data indicate that there are usually separately payable codes that are billed on claims with CPT codes 36500 and 75893. However, we acknowledge that these two codes may occasionally be provided without any separately payable procedures. In these uncommon instances, the provider historically has not received any payment under the OPPS. We also understand that there is a cost associated with registering a patient and providing these services. For CY 2006, we have approximately 160 single claims for CPT code 75893, with a median cost of $269. Based on the proposal described below for ''special'' packaged codes, for CY 2007, when CPT codes 36500 and 75893 are billed on a claim with no separately payable OPPS services, CPT code 75893 would become separately payable and would receive payment for APC 0668. In this circumstance, payment for CPT code 36500 would be packaged into the separate payment for CPT code 75893.

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

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

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

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

CPT code	Descriptor	Proposed CY 2007 APC	Proposed status indicator	Proposed CY 2007 APC median
36540	Collect blood, venous access device	0624	S	$32.96
36600	Arterial puncture; withdrawal of blood for diagnosis	0035	T	12.45
38792	Sentinel node identification	0389	S	86.92
75893	Venous sampling through catheter, with or without angiography, radiological supervision and interpretation.	0668	S	393.35
94762	Noninvasive ear or pulse oximetry for oxygen saturation by continuous overnight monitoring.	0443	X	61.39
96523	Irrigation of implanted venous access device	0624	S	32.96

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

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

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

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

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

For CY 2007, we are proposing to accept the APC Panel's recommendation to continue to package HCPCS code G0269. This code should never be billed without another separately payable procedure. Recent data indicate that 94 percent of the time HCPCS code G0269 was billed with either CPT code 93510 or 93526. In addition, the median cost of G0269 is low compared to the costs of the procedures with which it is typically associated.

For CY 2007, we are proposing to continue packaging CPT codes 94760 (Noninvasive ear or pulse oximetry for oxygen saturation; single determination) and 94761 (Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations) and not adopt the APC Panel's recommendation to provide separate payment for these services if there are no other separately payable OPPS services on the claim for the same date of service. Our data review revealed that these services are very frequently provided in the OPPS, with over 1 million claims in CY 2005 for the single pulse oximetry determination service and over 400,000 claims for the multiple determinations service. These high frequencies may actually be understated as both of these services are packaged codes, and we have been told that some hospitals may not report the

HCPCS codes for services for which they receive no separate payments. Single and multiple pulse oximetry determinations are almost always provided in association with other services that are separately payable under the OPPS, into which their costs may be appropriately packaged. Specifically, OPPS hospital claims data revealed that out of the total instances of CPT code 94760 appearing on claims used for setting payment rates for this CY 2007 OPPS proposed rule, CPT code 94760 was billed only 4 percent of the time in association with no other separately payable OPPS services, with a median cost of $14. Using the same data, CPT code 94761 was billed only 7 percent of the time in association with no other separately payable OPPS services, with a median cost of $36. These pulse oximetry services have a relatively low cost compared with the OPPS services they frequently accompany. If we were to provide separate payment for these pulse oximetry determinations when performed as stand alone procedures by hospitals, we are concerned that hospitals would lose their incentive to provide these basic, low cost, and brief services as efficiently as possible, generally during the same encounters where they are providing other services to the same patients. We believe their appropriate provision as single services should be very rare. Therefore, for CY 2007 we are proposing not to include these codes on the list of ''special'' packaged codes, so their payment would remain packaged in all circumstances.

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

The APC Panel Packaging Subcommittee remains active, and additional issues and new data concerning the packaging status of codes will be shared for its consideration as information becomes available. We continue to encourage submission of common clinical scenarios involving currently packaged HCPCS codes to the Packaging Subcommittee for its ongoing review. Additional detailed suggestions for the Packaging Subcommittee should be submitted to *APCPanel@cms.hhs.gov,* with ''Packaging Subcommittee'' in the subject line.

B. Proposed Payment for Partial Hospitalization

(If you choose to comment on issues in this section, please include the caption ''Partial Hospitalization'' at the beginning of your comment.)

1. Background

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

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

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

In the CY 2004 OPPS update, the median per diem cost for CMHCs grew to $1,038, while the median per diem cost for hospital-based PHPs was again $225. After applying the .583 adjustment factor in the CY 2004 proposed rule to the median CMHC per diem cost, the median CMHC per diem cost was $605. Because the CMHC median per diem cost exceeded the average per diem cost of inpatient psychiatric care, we proposed a per diem rate for CY 2004 based solely on hospital-based PHP data. The proposed PHP per diem for CY 2004, after scaling, was $208.95. However, by the time we published the OPPS final rule with comment period for CY 2004, we had received updated CCRs for CMHCs. Using the updated CCRs significantly lowered the CMHC median per diem cost to $440. As a result, we determined that the higher per diem cost for CMHCs was not due to the difference between ''as submitted'' and ''final settled'' cost reports, but was the result of excessive increases in charges which may have been done in order to receive higher outlier payments. Therefore, in calculating the PHP median per diem cost for CY 2004, we did not apply the .583 adjustment factor to CMHC costs to compute the PHP APC. Using the updated CCRs for CMHCs, the combined hospital-based and CMHC median per diem cost for PHP was $303. After scaling, we established the CY 2004 PHP APC of $286.82.

For CY 2005, the PHP per diem amount was based on 12 months of hospital and CMHC PHP claims data (for services furnished from January 1, 2003, through December 31, 2003). We used data from all hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs because CMHCs are Medicare

providers only for the purpose of providing partial hospitalization services. We used CCRs from the most recently available hospital and CMHC cost reports to convert each provider's line-item charges as reported on bills, to estimate the provider's cost for a day of PHP services. Per diem costs were then computed by summing the line-item costs on each bill and dividing by the number of days on the bill.

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

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

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

Following the methodology used for the CY 2005 OPPS update, the CY 2006 OPPS update combined hospital-based and CMHC median per diem cost was $161, a decrease of 44 percent compared to the CY 2005 combined median per diem amount. We believed that this amount was too low to cover the cost for all PHPs.

Therefore, as stated in the CY 2006 OPPS final rule with comment period (70 FR 68548 and 68549), we considered the following three alternatives to our update methodology for the PHP APC for CY 2006 to mitigate this drastic reduction in payment for PHP services: (1) Base the PHP APC on hospital-based PHP data alone; (2) apply a different trimming methodology to CMHC costs in an effort to eliminate the effect of data for those CMHCs that appeared to have excessively increased their charges in order to receive outlier payments; and (3) apply a 15 percent reduction to the combined hospital-based and CMHC median per diem cost that was used to establish the CY 2005 PHP APC. (We refer readers to the CY 2006 OPPS final rule with comment period for a full discussion of the three alternatives (70 FR 68548).) After carefully considering these three alternatives and all comments received on them, we adopted the third alternative for CY 2006. We adopted this alternative because we believed and continue to believe that a reduction in the CY 2005 median per diem cost would strike an appropriate balance between using the best available data and providing adequate payment for a program that often spans 5–6 hours a day. We believe that 15 percent is an appropriate reduction because it recognizes decreases in median per diem costs in both the hospital data and the CMHC data, and also reduces the risk of any adverse impact on access to these services that might result from a large single-year rate reduction. However, we adopted this policy as a transitional measure, and stated in the CY 2006 OPPS final rule with comment period that we would continue to monitor CMHC costs and charges for these services and work with CMHCs to improve their reporting so that payments can be calculated based on better empirical data, consistent with the approach we have used to calculate payments in other areas of the OPPS (70 FR 68548).

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

2. Proposed PHP APC Update for CY 2007

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

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

While the combined hospital-based and CMHC median per diem cost is about $10 higher using the CY 2005 data compared to the CY 2004 data ($172 compared to $161), we believe this amount is still too low to cover the cost for PHPs. We continue to believe that the policy we adopted for CY 2006—a 15-percent reduction applied to the current median cost—provides an appropriate decrease in median per diem costs for both the hospital and CMHC data. Therefore, for CY 2007, we are proposing an additional 15 percent reduction to the combined hospital-based and CMHC median per diem cost. We will continue to monitor and work with CMHCs to improve their reporting. If CMHC data continues to be a problem, we would consider using data from hospital-based PHPs only.

To calculate the CY 2007 APC PHP per diem cost, we reduced $245.65 (the CY 2005 combined hospital-based and CMHC median per diem cost of $289 reduced by 15 percent) by 15 percent, which resulted in a combined median per diem cost of $208.80.

3. Proposed Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469), we indicated that, given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. There was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP. In addition, further analysis indicated that using the same OPPS outlier threshold for both hospitals and CMHCs did not limit outlier payments to high cost cases and resulted in excessive outlier payments to CMHCs. Therefore, for CYs 2004, 2005, and 2006, we established a separate outlier threshold for CMHCs. For CYs 2004 and 2005, we designated a portion of the

estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in each of those years, excluding outlier payments. For CY 2006, we set the estimated outlier target at 1.0 percent and allocated a portion of that 1.0 percent, 0.6 percent (or 0.006 percent of total OPPS payments), to CMHCs for PHP services. The CY 2006 CMHC outlier threshold is met when the cost of furnishing services by a CMHC exceeds 3.40 times the PHP APC payment amount. The CY 2006 OPPS outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

The separate outlier threshold for CMHCs became effective January 1, 2004, and has resulted in more commensurate outlier payments. In CY 2004, the separate outlier threshold for CMHCs resulted in $1.8 million in outlier payments to CMHCs. In CY 2005, the separate outlier threshold for CMHCs resulted in $0.5 million in outlier payments to CMHCs. In contrast, in CY 2003, more than $30 million was paid to CMHCs in outlier payments. We believe this difference in outlier payments indicates that the separate outlier threshold for CMHCs has been successful in keeping outlier payments to CMHCs in line with the percentage of OPPS payments made to CMHCs.

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

As noted in section II.G. of this preamble, for CY 2007, we are proposing to continue our policy of setting aside 1.0 percent of the aggregate total payments under the OPPS for outlier payments. We are proposing that a portion of that 1.0 percent, an amount equal to 0.25 percent of outlier payments and 0.0025 percent of total OPPS payments would be allocated to CMHCs for PHP service outliers. As discussed in section II.G. of this preamble, we again are proposing to set a dollar threshold in addition to an APC multiplier threshold for OPPS outlier payments. However, because the PHP is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we are not proposing to set a dollar threshold for CMHC outliers. As noted above, we are proposing to set the outlier threshold for CMHCs for CY 2007 at 3.40 percent times the APC payment amount and the CY 2007 outlier payment percentage applicable to costs in excess of the threshold at 50 percent.

CMS and the Office of the Inspector General are continuing to monitor the excessive outlier payments to CMHCs.

C. Proposed Conversion Factor Update for CY 2007

(If you choose to comment on issues in this section, please include the caption ''Conversion Factor'' at the beginning of your comment.)

Section 1833(t)(3)(C)(ii) of the Act requires us to update the conversion factor used to determine payment rates under the OPPS on an annual basis. Section 1833(t)(3)(C)(iv) of the Act provides that, for CY 2007, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

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

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for CY 2006 to ensure that the revisions we are making to our updates for a revised wage index and expanded rural adjustment are made on a budget neutral basis. We calculated a budget neutrality factor of 0.999908021 for wage index changes by comparing total payments from our simulation model using the FY 2007 IPPS proposed wage index values to those payments using the current (FY 2006) IPPS wage index values. To reflect the inclusion of essential access community hospitals (EACHs) as rural SCHs (discussed in section II.F. of this preamble), we calculated an additional budget neutrality factor of 0.999883468 for the rural adjustment, including EACHs. For CY 2007, we estimate that allowed pass-through spending would equal approximately $43.2 million, which represents 0.13 percent of total OPPS projected spending for CY 2007. The proposed conversion factor also is adjusted by the difference between the 0.17 percent pass-through dollars set-aside in CY 2006 and the 0.13 percent estimate for CY 2007 pass-through spending. Finally, proposed payments for outliers remain at 1.0 percent of total payments for CY 2007.

The proposed market basket increase update factor of 3.4 percent for CY 2007, the required wage index budget neutrality adjustment of approximately 0.999908021, the return of 0.04 percent for the difference in the pass-through set-aside, and the proposed adjustment for the rural payment adjustment for rural SCHs, including rural EACHs, of 0.999883468 result in a proposed conversion factor for CY 2007 of $61.551.

D. Proposed Wage Index Changes for CY 2007

(If you choose to comment on issues in this section, please include the caption ''OPPS: Wage Indices'' at the beginning of your comment.)

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor and labor-related cost. This adjustment must be made in a budget neutral manner. As we have done in prior years, we are proposing to adopt the IPPS wage indices and extend these wage indices to hospitals that participate in the OPPS but not the IPPS (referred to in this section as ''non-IPPS'' hospitals).

As discussed in section II.A. of this preamble, we standardize 60 percent of estimated costs (labor-related costs) for geographic area wage variation using the IPPS wage indices that are calculated prior to adjustments for reclassification to remove the effects of differences in area wage levels in determining the OPPS payment rate and the copayment standardized amount.

As published in the original OPPS April 7, 2000 final rule with comment period (65 FR 18545), OPPS has consistently adopted the final IPPS wage indices as the wage indices for adjusting the OPPS standard payment amounts for labor market differences. Thus, the wage index that applies to a particular hospital under the IPPS will also apply to that hospital under the OPPS. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that using the IPPS wage index as the source of an adjustment factor for OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient within the hospital overall. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. In this proposed rule, we are using the

proposed FY 2007 hospital IPPS wage indices published in the **Federal Register** on April 25, 2006, which include the wage indices proposed to be in effect through March 31, 2007, and those proposed to be in effect on or after April 1, 2007, to accommodate the expiring reclassification provisions under section 508 of Pub. L. 108–173, to determine the wage adjustments for the OPPS payment rate and the copayment standardized amount for CY 2007. However, in accordance with our established policy, we are proposing to use the FY 2007 final version of these wage indices to determine the wage adjustments for the OPPS payment rate and copayment standardized amount that we will publish in our final rule for CY 2007.

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

We note that the FY 2007 IPPS wage indices continue to reflect a number of changes implemented in FY 2005 as a result of the revised Office of Management and Budget (OMB) standards for defining geographic statistical areas, the implementation of an occupational mix adjustment as part of the wage index, and new wage adjustments provided for under Pub. L. 108–173. The following is a brief summary of the proposed changes in the FY 2005 IPPS wage indices, continued for FY 2007, and any adjustments that we are applying to the OPPS for CY 2007. We refer the reader to the FY 2007 IPPS proposed rule (71 FR 24074 through 24091) for a detailed discussion of the proposed changes to the wage indices. Readers should refer to our proposed rule published May 17, 2006, for proposed changes to the occupational mix adjustment and related issues (71 FR 28644–28653). In this proposed rule, we are not reprinting the proposed FY 2007 IPPS wage indices. We also refer readers to the CMS Web site for the OPPS at *http://www.cms.hhs.gov/providers/hopps.* At this Web site, the reader will find a link to the proposed FY 2007 IPPS wage indices tables. (However, as noted above, these tables may change as a result of the May 17, 2006 occupational mix proposed rule discussed above.)

1. *The proposed continued use of the Core Based Statistical Areas (CBSAs) issued by the OMB as revised standards for designating geographical statistical areas based on the 2000 Census data, to define labor market areas for hospitals for purposes of the IPPS wage index.* The OMB revised standards were published in the **Federal Register** on December 27, 2000 (65 FR 82235), and OMB announced the new CBSAs on June 6, 2003, through an OMB bulletin. In the FY 2005 IPPS final rule, CMS adopted the new OMB definitions for wage index purposes. In the FY 2007 IPPS proposed rule, we again stated that hospitals located in MSAs will be urban and hospitals that are located in Micropolitan Areas or outside CBSAs will be rural. To help alleviate the decreased payments for previously urban hospitals that became rural under the new geographical definitions, we allowed these hospitals to maintain for the 3-year period from FY 2005 through FY 2007, the wage index of the MSA where they previously had been located. To be consistent with the IPPS, we will continue the policy we began in CY 2005 of applying the same urban-to-rural transition to non-IPPS hospitals paid under the OPPS. That is, we would maintain the wage index of the MSA where the hospital was previously located for purposes of determining a wage index for CY 2007. Beginning in FY 2008, the 3-year transition will end and these hospitals will receive their statewide rural wage index. However, hospitals paid under the IPPS will be eligible to apply for reclassification.

For the occupational mix adjustment, we refer readers to CMS's May 17, 2006 occupational mix proposed rule discussed above. Under this proposed rule, wage indices would be adjusted 100 percent for occupational mix. In addition, as stated above, CMS plans that wage index tables and other adjustment factors would be published after publication of the FY 2007 IPPS final rule, but prior to October 1, 2006.

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

2. *The reclassifications of hospitals to geographic areas for purposes of the wage index.* For purposes of the OPPS wage index, we are proposing to adopt all of the IPPS reclassifications for FY 2007, including reclassifications that the Medicare Geographic Classification Review Board (MGCRB) approved under the one-time appeal process for hospitals under section 508 of Pub. L. 108–173. We note that section 508 reclassifications will terminate March 31, 2007, and that this expiration, along with the calendar year operating period of OPPS, impacts the calculation of the OPPS payment and the budget neutrality adjustment for the wage index. In the FY 2007 IPPS proposed rule (71 FR 24085 through 24087), we proposed procedural rules for hospitals that wished to reclassify for the second half of FY 2007 (April 1, 2007, through September 30, 2007) under section 1886(d)(10) of the Act. These rules essentially provided procedures for some hospitals to retain section 508 reclassifications for the first half of FY 2007 and also be eligible to maintain an approved reclassification under section 1886(d)(10) for the second half of FY 2007. Rather than calculating one wage index that reflected all final reclassification adjustments, we proposed two separate wage indices for FY 2007, one to be in effect October 1 through March 31, 2007, and one to be in effect April 1 through September 30, 2007.

These procedural rules also impact a hospital's eligibility to receive the out-migration wage adjustment, discussed in greater detail in section III.I. of the FY 2007 IPPS proposed rule (71 FR 24087) and under section II.D.4. of this preamble. A hospital cannot receive an out-migration wage adjustment if it is reclassified under section 1886(d)(10) of the Act. Hospitals declining reclassification status for any part of the year become eligible to receive the out-migration wage adjustment if they are located in an adjustment county.

Because the OPPS operates on a calendar year (January 1 through December 31) and not a fiscal year, the expiring reclassification status under section 508 of Pub. L. 108–173 results in different wage indices for OPPS for the first quarter of CY 2007 (January 1, 2007, through March 31, 2007) and the last three quarters of CY 2007 (April 1, 2007, through December 31, 2007).

3. *The out-migration wage adjustment to the wage index.* In FY 2007 IPPS proposed rule (71 FR 24087), we discussed the out-migration adjustment under section 505 of Pub. L. 109–173 for counties under this adjustment. Hospitals paid under the IPPS located in the qualifying section 505 ''out-migration'' counties receive a wage index increase unless they have already been otherwise reclassified. (See the IPPS FY 2007 proposed rule for further information on out-migration.) For OPPS purposes, we propose to continue our policy from CY 2006 to allow non-IPPS hospitals paid under the OPPS to qualify for out-migration adjustment if they are located in a section 505 out-migration county. Because non-IPPS hospitals cannot reclassify, they are eligible for the out-migration wage adjustment. Tables identifying counties eligible for the out-migration adjustment will be published after the FY 2007 IPPS final rule and CMS plans to publish them in advance of October 1, 2006. These tables will reflect updated county listing to reflect changes to the occupation mix adjustment made in response to *Bellevue* court case discussed above. Because we are proposing to adopt the final FY 2007 IPPS wage index, we will adopt any changes in a hospital's classification status that would make them either eligible or ineligible for the out-migration wage adjustment both through March 31, 2007, and on or after April 1, 2007.

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

Under the procedural rules described under section II.D.3. of this proposed rule above and in section III.H.5. of the FY 2007 IPPS proposed rule (71 FR 24085) regarding expiring section 508 reclassifications, different wage indices may be in effect for the first quarter of the calendar year and the last three quarters of the calendar year. These rules have implications for budget neutrality adjustments. Any additional payment attributable to reclassifications due to section 508 between January 1 and April 1, 2007, must be excluded from a budget neutrality adjustment, and all other adjustments to the wage index are subject to budget neutrality. Rather than calculating two different conversion factors, with different budget neutrality adjustments, we are proposing to calculate one budget neutrality adjustment that reflects the combined adjustments required for the first quarter and last three quarters of the calendar year, respectively. We followed the same approach in the FY 2007 IPPS proposed rule (71 FR 24087).

E. Proposed Statewide Average Default CCRs

(If you choose to comment on issues in this section, please include the caption ''OPPS: Cost-to-Charge Ratios'' at the beginning of your comment.)

CMS uses CCRs to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS. Some hospitals do not have a valid CCR. These hospitals include, but are not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds for a valid CCR, or hospitals that have recently given up their all-inclusive rate status. Last year, we updated the default urban and rural CCRs for CY 2006 in our final rule, published on November 10, 2005 (70 FR 68553 through 68555). In this proposed rule, we are proposing to update the default ratios for CY 2007 using the most recent cost report data.

We calculated the statewide default CCRs using the same overall CCRs that we use to adjust charges to costs on claims data. Please refer to section II.A.1.c. of this preamble for a discussion of our proposed revision to the overall CCR calculation. Table 4 lists the proposed CY 2007 default urban and rural CCRs by State and compares them to last year's default CCRs. These CCRs are the ratio of total costs to total charges from each provider's most recently submitted cost report, for those cost centers relevant to outpatient services weighted by Medicare Part B charges. We also adjusted these ratios to reflect final settled status by applying the differential between settled to submitted costs and charges from the most recent pair of settled to submitted cost reports.

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

Finally, we calculated an overall average CCR, weighted by a measure of volume for CY 2004, for each State except Maryland. This measure of volume is the total lines on claims and is the same one that we use in our impact tables. For Maryland, we used an overall weighted average CCR for all hospitals in the Nation as a substitute for Maryland CCRs, which appear in Table 4. Very few providers in Maryland are eligible to receive payment under the OPPS, which limits the data available to calculate an accurate and representative CCR. The observed differences between last year's default statewide CCRs and the proposed CCRs are a combination of the general decline in the ratio between costs and charges widely observed in the cost report data and the change in the proposed overall CCR calculation.

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

State	Urban/Rural	Previous Default CCR (CY 2006 OPPS Final Rule)	Default CCR (CY 2007 Proposed Rule)
ALABAMA	RURAL	0.23418	0.23848
ALABAMA	URBAN	0.21741	0.22622
ALASKA	RURAL	0.54605	0.50899
ALASKA	URBAN	0.39832	0.38447
ARIZONA	RURAL	0.30658	0.29252
ARIZONA	URBAN	0.24132	0.23972
ARKANSAS	RURAL	0.29108	0.27462
ARKANSAS	URBAN	0.27611	0.2851
CALIFORNIA	RURAL	0.26409	0.25004
CALIFORNIA	URBAN	0.22126	0.23368
COLORADO	RURAL	0.39223	0.36875
COLORADO	URBAN	0.28236	0.27766
CONNETICUT	RURAL	0.38081	0.3996
CONNETICUT	URBAN	0.38571	0.3619
DELAWARE	RURAL	0.35359	0.34217
DELAWARE	URBAN	0.42436	0.38385
DISTRICT OF	URBAN	0.34874	0.35563

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State	Urban/Rural	Previous Default CCR (CY 2006 OPPS Final Rule)	Default CCR (CY 2007 Proposed Rule)
COLUMBIA			
FLORIDA	RURAL	0.22179	0.23522
FLORIDA	URBAN	0.20998	0.20922
GEORGIA	RURAL	0.30927	0.29765
GEORGIA	URBAN	0.29195	0.29652
HAWAII	RURAL	0.34871	0.35833
HAWAII	URBAN	0.32641	0.31973
IDAHO	RURAL	0.41757	0.43046
IDAHO	URBAN	0.46269	0.44003
ILLINOIS	RURAL	0.31279	0.31332
ILLINOIS	URBAN	0.27474	0.28922
INDIANA	RURAL	0.35138	0.32102
INDIANA	URBAN	0.3498	0.32312
IOWA	RURAL	0.40375	0.39978
IOWA	URBAN	0.34645	0.34709
KANSAS	RURAL	0.34407	0.33427
KANSAS	URBAN	0.26461	0.26187
KENTUCKY	RURAL	0.28358	0.26221
KENTUCKY	URBAN	0.29116	0.27205
LOUISIANA	RURAL	0.27617	0.28148
LOUISIANA	URBAN	0.25738	0.27371
MAINE	RURAL	0.385	0.42345
MAINE	URBAN	0.43839	0.42616
MARYLAND	RURAL	0.3362	0.32614
MARYLAND	URBAN	0.30235	0.30353
MASSACHUSETTS	URBAN	0.34321	0.3511
MICHIGAN	RURAL	0.36976	0.35363
MICHIGAN	URBAN	0.33319	0.33755
MINNESOTA	RURAL	0.46788	0.49593
MINNESOTA	URBAN	0.34301	0.34369
MISSISSIPPI	RURAL	0.28672	0.29642
MISSISSIPPI	URBAN	0.25325	0.24606
MISSOURI	RURAL	0.30823	0.29987
MISSOURI	URBAN	0.2907	0.30528
MONTANA	RURAL	0.45445	0.43682
MONTANA	URBAN	0.41281	0.46472
NEBRASKA	RURAL	0.39625	0.37935
NEBRASKA	URBAN	0.29024	0.29122

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State	Urban/Rural	Previous Default CCR (CY 2006 OPPS Final Rule)	Default CCR (CY 2007 Proposed Rule)
NEVADA	RURAL	0.46867	0.37343
NEVADA	URBAN	0.21197	0.21756
NEW HAMPSHIRE	RURAL	0.37552	0.37656
NEW HAMPSHIRE	URBAN	0.32278	0.32278
NEW JERSEY	URBAN	0.28231	0.29955
NEW MEXICO	RURAL	0.29838	0.27646
NEW MEXICO	URBAN	0.37082	0.38823
NEW YORK	RURAL	0.43021	0.43867
NEW YORK	URBAN	0.41179	0.42315
NORTH CAROLINA	RURAL	0.32018	0.32241
NORTH CAROLINA	URBAN	0.35682	0.37787
NORTH DAKOTA	RURAL	0.37434	0.36243
NORTH DAKOTA	URBAN	0.36945	0.36858
OHIO	RURAL	0.38349	0.366
OHIO	URBAN	0.30535	0.2849
OKLAHOMA	RURAL	0.31287	0.30327
OKLAHOMA	URBAN	0.27113	0.26631
OREGON	RURAL	0.38707	0.35467
OREGON	URBAN	0.3986	0.40869
PENNSYLVANIA	RURAL	0.32748	0.30925
PENNSYLVANIA	URBAN	0.25961	0.25357
PUERTO RICO	URBAN	0.42501	0.48156
RHODE ISLAND	URBAN	0.30402	0.31786
SOUTH CAROLINA	RURAL	0.25726	0.28136
SOUTH CAROLINA	URBAN	0.25645	0.27408
SOUTH DAKOTA	RURAL	0.37687	0.36726
SOUTH DAKOTA	URBAN	0.31324	0.31922
TENNESSEE	RURAL	0.28343	0.27491
TENNESSEE	URBAN	0.2595	0.2558
TEXAS	RURAL	0.30769	0.30747
TEXAS	URBAN	0.27468	0.27448
UTAH	RURAL	0.47797	0.44525
UTAH	URBAN	0.43421	0.43018
VERMONT	RURAL	0.44428	0.42728

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State	Urban/Rural	Previous Default CCR (CY 2006 OPPS Final Rule)	Default CCR (CY 2007 Proposed Rule)
VERMONT	URBAN	0.39407	0.35054
VIRGINIA	RURAL	0.29042	0.28773
VIRGINIA	URBAN	0.2976	0.29006
WASHINGTON	RURAL	0.40571	0.37823
WASHINGTON	URBAN	0.381	0.38207
WEST VIRGINIA	RURAL	0.32565	0.31576
WEST VIRGINIA	URBAN	0.38024	0.38494
WISCONSIN	RURAL	0.39136	0.36842
WISCONSIN	URBAN	0.3672	0.37414
WYOMING	RURAL	0.4687	0.4701
WYOMING	URBAN	0.38414	0.32782

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

For CY 2007, we are proposing to apply this treatment of using the default statewide CCR to include an entity that has not accepted assignment of an existing hospital's provider agreement in accordance with 42 CFR 489.18, and that has not yet submitted its first Medicare cost report. We are proposing that this policy be effective for hospitals experiencing a change of ownership on or after January 1, 2007. We believe that a hospital that has not accepted assignment of an existing hospital's provider agreement is similar to a new hospital that will establish its own costs and charges. We believe that the hospital that has chosen not to accept assignment may have different costs and charges than the existing hospital. Furthermore, we believe that the hospital should be provided time to establish its own costs and charges. Therefore, we are proposing to use the default statewide CCR to determine cost-based payments until the hospital has submitted its first Medicare cost report.

F. OPPS Payments to Certain Rural Hospitals

(If you choose to comment on issues in this section, please include the caption ''OPPS: Rural Hospitals Hold Harmless Transitional Payments'' at the beginning of your comment.)

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

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

Section 5105 of Pub. L. 109–171 reinstituted the hold harmless transitional outpatient payments (TOPs) for covered OPD services furnished on or after January 1, 2006, and before January 1, 2009, for rural hospitals having 100 or fewer beds that are not SCHs. When the OPPS payment is less than the payment the provider would have received under the previous reasonable cost-based system, the amount of payment is increased by 95 percent of the amount of the difference between those two payment systems for CY 2006, by 90 percent of the amount of that difference for CY 2007, and by 85 percent of the amount of that difference for CY 2008.

For CY 2006, we have implemented section 5106 of Pub. L. 109–171 through Transmittal 877, issued on February 24, 2006. We did not specifically address whether TOPs payments apply to EACHs, which are considered to be SCHs under section 1886(d)(5)(D)(iii)(III) of the Act. Accordingly, under the statute, EACHs are treated as SCHs. Therefore, we believe that EACHs are not eligible for TOPs payment under Pub. L. 109–171. We are proposing to update § 419.70(d)

to reflect the requirements of Pub. L. 109–171.

2. Proposed Adjustment for Rural SCHs Implemented in CY 2006 Related to Pub. L. 108–173 (MMA)

(If you choose to comment on issues in this section, please include the caption ''OPPS: Rural SCH Payments'' at the beginning of your comment.)

In the CY 2006 OPPS final rule with comment period (70 FR 68556), we finalized a payment increase for rural SCHs of 7.1 percent for all services and procedures paid under the OPPS, excluding drugs, biologicals, brachytherapy seeds, and services paid under pass-through payment policy in accordance with section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108–173. Section 411 gave the Secretary the authority to make an adjustment to OPPS payments for rural hospitals effective January 1, 2006 if justified by a study of the difference in costs by APC between hospitals in rural and urban areas. Our analysis showed a difference in costs only for rural SCHs and we implemented a payment adjustment for those hospitals beginning January 1, 2006.

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

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

G. Proposed CY 2007 Hospital Outpatient Outlier Payments

(If you choose to comment on issues in this section, please include the caption ''Outlier Payments'' at the beginning of your comment.)

Currently, the OPPS pays outlier payments on a service-by-service basis. For CY 2006, the outlier threshold is met when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,250 fixed-dollar threshold. We introduced a fixed-dollar threshold in CY 2005 in addition to the traditional multiple threshold in order to better target outliers to those high cost and complex procedures where a very costly service could present a hospital with significant financial loss. If a provider meets both of these conditions, the multiple threshold and the fixed-dollar threshold, the outlier payment is calculated as 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate. For a discussion on CMHC outliers, see section II.B.3. of the preamble to this proposed rule.

As explained in our CY 2006 OPPS final rule with comment period (70 FR 68561), we set our projected target for aggregate outlier payments at 1.0 percent of aggregate total payments under the OPPS. Our outlier thresholds were set so that estimated CY 2006 aggregate outlier payments would equal 1.0 percent of aggregate total payments under the OPPS. In our CY 2006 OPPS final rule with comment period (70 FR 68563), we also published total outlier payments as a percent of total expenditures for past years. At this time, we do not have a complete set of CY 2005 claims in order to produce this number for CY 2005. We will report on CY 2005 outlier payments in our CY 2007 OPPS final rule.

For CY 2007, we are proposing to continue our policy of setting aside 1.0 percent of aggregate total payments under the OPPS for outlier payments. A portion of that 1.0, an amount equal to 0.25 percent of outlier payments and 0.0025 percent of total OPPS payments would be allocated to CMHCs for partial hospitalization program service outliers.

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

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

The claims that we use to model each OPPS lag by 2 years. For this proposed rule, we used CY 2005 claims to model the CY 2007 OPPS. In order to estimate CY 2007 outlier payments for this proposed rule, we inflated the charges on the CY 2005 claims using the same inflation factor of 1.1515 that we used to estimate the IPPS fixed-dollar outlier threshold for the IPPS FY 2007 proposed rule. For 1 year, the inflation factor is 1.0757. The methodology for determining this charge inflation factor was discussed in the FY 2007 IPPS proposed rule (71 FR 24150). As we stated in our CY 2005 final rule with comment period, we believe that the use of this charge inflation factor is appropriate for OPPS because, with the exception of the routine service cost centers, hospitals use the same cost centers to capture costs and charges across inpatient and outpatient services (69 FR 65845, November 15, 2004). As also noted in the FY 2006 IPPS final rule, we believe that a charge inflation factor is more appropriate than an adjustment to costs because this methodology closely captures how

actual outlier payments are made and calculated (70 FR 47495, August 12, 2005). We then applied the revised overall CCR that we calculated from each hospital's most recent cost report (CMS–2552–96) and, if the cost report was not settled, we adjusted it by a settled-to-submitted ratio. We simulated aggregated outlier payments using these costs for several different fixed-dollar thresholds holding the 1.75 multiple constant until the total outlier payments equaled 1.0 percent of aggregated total OPPS payments. We estimate that a threshold of $1,825 combined with the multiple threshold of 1.75 times the APC payment rate would allocate 1.0 percent of aggregated total OPPS payments to outlier payments.

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

The following is an example of an outlier calculation for CY 2007 under our proposed policy. A hospital charges $20,000 for a procedure. The wage adjusted, and rural adjusted, if applicable, APC payment for the procedure is $3,500. Using the provider's CCR of 0.35, the estimated cost to the hospital is $7,000 (0.35 × $20,000). To determine whether this provider is eligible for outlier payments for this procedure, the provider must determine whether the cost for the service exceeds both the APC outlier cost threshold (1.75 × APC payment) and the fixed-dollar threshold ($1,825 + APC payment). In this example, the provider meets both criteria:

(1) $7,000 exceeds $6,125 (1.75 × $3,500)

(2) $7,000 exceeds $5,325 ($3,500 + $1,825)

To calculate the outlier payment, which is 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC rate, subtract $6,125 (1.75 × $3,500) from $7,000 (resulting in $825). The provider is eligible for 50 percent of the difference, in this case $437.50 ($825/2). The formula is (cost − (1.75 × APC payment rate))/2.

H. Calculation of the Proposed OPPS National Unadjusted Medicare Payment

(If you choose to comment on issues in this section, please include the caption ''OPPS: National Unadjusted Medicare Payment'' at the beginning of your comment.)

The basic methodology for determining prospective payment rates for OPD services under the OPPS is set forth in existing regulations at § 419.31 and § 419.32. The payment rate for services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section II.C. of this proposed rule and the relative weight determined under section II.A. of this proposed rule. Therefore, the national unadjusted payment rate for APCs contained in Addendum A to this proposed rule and for HCPCS codes to which payment under the OPPS has been assigned in Addendum B to this proposed rule (Addendum B is provided as a convenience for readers) was calculated by multiplying the proposed CY 2007 scaled weight for the APC by the proposed CY 2007 conversion factor.

However, to determine the payment that will be made in a calendar year under the OPPS to a specific hospital for an APC for a service other than a drug, in a circumstance in which the multiple procedure discount does not apply, we take the following steps:

Step 1. Calculate 60 percent (the labor-related portion) of the national unadjusted payment rate. Since the initial implementation of the OPPS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. (Refer to the April 7, 2000 final rule with comment period (65 FR 18496 through 18497) for a detailed discussion of how we derived this percentage.)

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area reflect the new geographic statistical areas as a result of revised OMB standards (urban and rural) to which hospitals are assigned for FY 2007 under the IPPS, reclassifications through the Medicare Classification Geographic Review Board, section 1866(d)(8)(B) ''Lugar'' hospitals, and section 401 of Pub. L. 108–173, and the reclassifications of hospitals under the one-time appeals process under section 508 of Pub. L. 108–173. The wage index values include the occupational mix adjustment described in section II.D. of this proposed rule that was developed for the proposed FY 2007 IPPS payment rates. We note that the original proposal for calculating the FY 2007 IPPS wage index has been recently changed. (Refer to the May 17, 2006 FY 2007 IPPS proposed rule, 71 FR 28644).) Final FY 2007 IPPS wage indices will be adjusted 100 percent for differences in occupational mix. Although we have not incorporated those changes in this proposed rule due to the availability of new survey data, as is our practice, we propose to adopt changes made to the FY 2007 IPPS wage index values after they have been finalized.

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county, but who work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173. Addendum L contains the qualifying counties and the proposed wage index increase developed for the FY 2007 IPPS. This step is to be followed only if the hospital has chosen not to accept reclassification under Step 2 above.

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

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

Step 6. If a provider is a SCH, as defined in § 419.92, and located in a rural area, as defined in § 412.63(b), or is treated as being located in a rural area under § 412.103 of the Act, multiply the wage index adjusted payment rate by 1.071 to calculate the total payment.

I. Proposed Beneficiary Copayments for CY 2007

(If you choose to comment on issues in this section, please include the caption ''OPPS: Beneficiary Copayments'' at the beginning of your comment.)

1. Background

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

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

2. Proposed Copayment for CY 2007

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

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

To calculate the OPPS adjusted copayment amount for an APC group, take the following steps:

Step 1. Calculate the beneficiary payment percentage for the APC by dividing the APC's national unadjusted copayment by its payment rate. For example, using APC 0001, $7.00 is 23 percent of $30.14.

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

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

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

A. Proposed Treatment of New HCPCS and CPT Codes

(If you choose to comment on issues in this section, please include the caption ''OPPS: New HCPCS and CPT Codes'' at the beginning of your comment.)

1. Proposed Treatment of New HCPCS Codes Included in the Second and Third Quarterly OPPS Updates for CY 2006

During the second and third quarters of CY 2006, we created a total of four new Level II HCPCS codes that were not addressed in the November 10, 2005 final rule with comment period that updated the CY 2006 OPPS. We have designated the payment status of those codes and added them either through the April update (Transmittal 896, dated March 24, 2006) or the July update of the CY 2006 OPPS (Transmittal 970, dated May 30, 2006). In this proposed rule, we are soliciting public comments on the status indicators and APC assignments of these services, which are listed in Table 5. Because of the timing of this proposed rule, those codes implemented through the July 2006 OPPS update are not included in Addendum B of this proposed rule, while those codes based upon the April 2006 OPPS update are included in Addendum B. We intend to finalize the assignments for all of these services in the OPPS CY 2007 final rule.

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

HCPCS code	Description	Assigned status indicator	Assigned APC	Implementation date
C9227	Injection, micafungin sodium, per 1 mg	G	9227	April 1, 2006.
C9228	Injection, tigecycline, per 1 mg	G	9228	April 1, 2006.
C9229	Injection ibandronate sodium	G	9229	July 1, 2006.
C9230	Injection, abatacept	G	9230	July 1, 2006.

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

As has been our practice in the past, we implement new Category I and III CPT codes and new Level II HCPCS codes, which are released in the fall of each year for annual updating, effective January 1 in the final rule updating the OPPS for the following calendar year. These codes are flagged with Comment Indicator ''NI'' in Addendum B of the OPPS final rule to indicate that we are assigning them an interim payment status which is subject to public comment following publication of the final rule that implements the annual OPPS update. (See the discussion immediately below concerning our modified policy for implementing new Category I and III mid-year CPT codes.) We are proposing to continue this recognition and process for CY 2007. New Category I and III CPT codes and new Level II HCPCS codes, effective January 1, 2007, will be designated in Addendum B of the CY 2007 OPPS final rule with Comment Indicator ''NI.'' The status indicator, the APC assignment, or both for all such codes flagged with Comment Indicator ''NI,'' will be open to public comment. We will respond to all comments received in a subsequent final rule.

3. Proposed Treatment of New Mid-Year CPT Codes

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

interim payment status which was subject to public comment following publication of the final rule that implemented the annual OPPS update.

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

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

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

Some of the new Category III CPT codes describe services that we have determined to be similar in clinical characteristics and resource use to HCPCS codes in an existing APC. In these instances, we may assign the Category III CPT code to the appropriate clinical APC. Other Category III CPT codes describe services that we have determined are not compatible with an existing clinical APC, yet are appropriately provided in the hospital outpatient setting. In these cases, we may assign the Category III CPT code to what we estimate is an appropriately priced New Technology APC. In other cases, we may assign a Category III CPT code one of several nonseparately payable status indicators, including N, C, B, or E, which we believe is appropriate for the specific code. We expect that we will have received applications for new technology status for some of the services described by new Category III CPT codes, which may assist us in determining appropriate APC assignments. If the AMA establishes a Category III CPT code for a service for which an application has been submitted to CMS for new technology status, CMS may not have to issue a temporary Level II HCPCS code to describe the service, as has often been the case in the past when Category III CPT codes were only recognized by the OPPS on an annual basis.

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

B. Proposed Changes—Variations Within APCs

(If you choose to comment on issues in this section, please include the caption ''OPPS: 2 Times Rule'' at the beginning of your comment.)

1. Background

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered hospital outpatient services. Section 1833(t)(2)(B) of the Act provides that this classification system may be composed of groups of services, so that services within each group are comparable clinically and with respect to the use of resources. In accordance with these provisions, we developed a grouping classification system, referred to as the Ambulatory Payment Classification Groups (or APCs), as set forth in § 419.31 of the regulations. We use Level I and Level II HCPCS codes and descriptors to identify and group the services within each APC. The APCs are organized such that each group is homogeneous both clinically and in terms of resource use. Using this classification system, we have established distinct groups of surgical, diagnostic, and partial hospitalization services, as well as medical visits. We also have developed separate APC groups for certain medical devices, drugs, biologicals, radiopharmaceuticals, and brachytherapy devices.

We have packaged into each procedure or service within an APC group the costs associated with those items or services that are directly related and integral to performing a procedure

or furnishing a service. Therefore, we do not make separate payment for packaged items or services. For example, packaged items and services include: (1) Use of an operating, treatment, or procedure room; (2) use of a recovery room; (3) most observation services; (4) anesthesia; (5) medical/surgical supplies; (6) pharmaceuticals (other than those for which separate payment may be allowed under the provisions discussed in section V of this preamble); and (7) incidental services such as venipuncture. Our packaging methodology is discussed in section II.A. of this proposed rule.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the APC group to which the service is assigned. Each APC weight represents the hospital median cost of the services included in that APC relative to the hospital median cost of the services included in APC 0606. The APC weights are scaled to APC 0606 because we are proposing it to be the middle level clinic visit APC (that is, where the Level III Clinic Visit HCPCS code of five proposed levels of clinic visits is assigned), and because middle level clinic visits are among the most frequently furnished services in the outpatient hospital setting. See section II.A.3. of this preamble for a complete discussion of the reasons for choosing APC 0606 as the basis for scaling the APC relative weights.

Section 1833(t)(9)(A) of the Act requires the Secretary to review the components of the OPPS not less than annually and to revise the groups and relative payment weights and make other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA of 1999, also requires the Secretary, beginning in CY 2001, to consult with an outside panel of experts to review the APC groups and the relative payment weights (the APC Panel recommendations for specific services for CY 2007 OPPS and our responses to them are discussed in section III.D. of this preamble).

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

2. Application of the 2 Times Rule

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

During the APC Panel's March 1–2, 2006 meeting, we presented median cost and utilization data for services furnished during the period of January 1, 2005, through September 30, 2005, about which we had concerns or about which the public had raised concerns regarding their APC assignments, status indicator assignments, or payment rates. The discussions of service-specific issues, the APC Panel recommendations if any, and our proposals for CY 2007 are contained in section III.D. of this preamble.

In addition to the assignment of specific services to APCs which we discussed with the APC Panel, we also identified APCs with 2 times violations that were not specifically discussed with the APC Panel but for which we are proposing changes to their HCPCS codes' APC assignments in Addendum B of this proposed rule. In these cases, to eliminate a 2 times violation, we reassigned the codes to APCs that contained services that were similar with regard to both resource use and clinical homogeneity. We also 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 changed the status indicators for some codes because we thought that another status indicator more accurately describes their payment status from an OPPS perspective based on our CY 2007 proposed policies.

Addendum B of this proposed rule identifies with a comment indicator ''CH'' those HCPCS codes for which we are proposing a change to the APC assignment or status indicator as assigned in the January 2006 Addendum B. These proposed reassignments of APC or status indicator are subject to public comment under this proposed rule.

3. Exceptions to the 2 Times Rule

As discussed earlier, we may make exceptions to the 2 times limit on the variation of costs within each APC group in unusual cases such as low-volume items and services. Taking into account the APC changes that we are proposing for CY 2007 based on the APC Panel recommendations discussed in section III.D. of this preamble, the proposed changes to status indicators and APC assignments as identified in Addendum B, and the use of CY 2005 claims data to calculate the median costs of procedures classified in the APCs, we reviewed all the APCs to determine which APCs would not satisfy the 2 times rule. We used the following criteria to decide whether to propose exceptions to the 2 times rule for affected APCs:

- Resource homogeneity
- Clinical homogeneity
- Hospital concentration
- Frequency of service (volume)
- Opportunity for upcoding and code fragments.

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

Table 7 lists the APCs that we are proposing to exempt from the 2 times rule based on the criteria cited above. For cases in which a recommendation by the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the APC Panel's recommendation because those recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine the APC payment rates that we are proposing for CY 2007. The median costs for hospital outpatient services for these and all other APCs which were used in development of this proposed rule can be found on the CMS Web site: *http://www.cms.hhs.gov.*

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

APC	APC description
0007	Level II Incision & Drainage.
0010	Level I Destruction of Lesion.
0019	Level I Excision/Biopsy.
0024	Level I Skin Repair.
0031	Smoking Cessation Services.
0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.
0043	Closed Treatment Fracture Finger/Toe/Trunk.
0058	Level I Strapping and Cast Application.
0060	Manipulation Therapy.
0081	Non-Coronary Angioplasty or Atherectomy.
0085	Level II Electrophysiologic Evaluation.
0093	Vascular Reconstruction/Fistula Repair without Device.
0105	Revision/Removal of Pacemakers, AICD, or Vascular.
0111	Blood Product Exchange.
0112	Apheresis, Photopheresis, and Plasmapheresis.
0204	Level I Nerve Injections.
0235	Level I Posterior Segment Eye Procedures.
0245	Level I Cataract Procedures without IOL Insert.
0251	Level I ENT Procedures.
0252	Level II ENT Procedures.
0274	Myelography.
0303	Treatment Device Construction.
0307	Myocardial Positron Emission Tomography (PET) Imaging.
0312	Radioelement Applications.
0323	Extended Individual Psychotherapy.
0330	Dental Procedures.
0409	Red Blood Cell Tests.
0418	Insertion of Left Ventricular Pacing Elect.
0432	Health and Behavior Services.
0437	Level II Drug Administration.
0604	Level I Clinic Visits.
0664	Level I Proton Beam Radiation Therapy.

C. New Technology APCs

(If you choose to comment on issues in this section, please include the caption ''New Technology APCs'' at the beginning of your comment.)

1. Introduction

In the November 30, 2001 final rule (66 FR 59903), we finalized changes to the time period a service was eligible for payment under a New Technology APC. Beginning in CY 2002, we retain services within New Technology APC groups until we gather sufficient claims data to enable us to assign the service to a clinically appropriate APC. This policy allows us to move a service from a New Technology APC in less than 2 years if sufficient data are available. It also allows us to retain a service in a New Technology APC for more than 3 years if sufficient data upon which to base a decision for reassignment have not been collected. We note that the cost bands for new technology APCs range from $0 to $50 in increments of $10, from $50 to $100 in an increment of $50, from $100 through $2,000 in intervals of $100, and from $2,000 through $6,000 in intervals of $500. These intervals, which are in two parallel sets of New Technology APCs, one with status indicator ''S'' and the other with status indicator ''T,'' allow us to price new technology services more appropriately and consistently.

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

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

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

We note that in a budget neutral environment, payments may not fully cover hospitals' costs, including those for the purchase and maintenance of capital equipment. We rely on providers to make their decisions regarding the acquisition of high cost equipment with the understanding that the Medicare

program must be careful to establish its initial payment rates for new services that lack hospital claims data based on realistic utilization projections for all such services delivered in cost-efficient hospital outpatient settings. As the OPPS acquires claims data regarding hospital costs associated with new procedures, we will regularly examine the claims data and any available new information regarding the clinical aspects of new procedures to confirm that our OPPS payments remain appropriate for procedures as they transition into mainstream medical practice.

2. Proposed Movement of Procedures From New Technology APCs to Clinical APCs

As we explained in the November 30, 2001 final rule (66 FR 59897), we generally keep a procedure in the New Technology APC to which it is initially assigned until we have collected data sufficient to enable us to move the procedure to a clinically appropriate APC. However, in cases where we find that our original New Technology APC assignment was based on inaccurate or inadequate information, or where the New Technology APCs are restructured, we may, based on more recent resource utilization information (including claims data) or the availability of refined New Technology APC bands, reassign the procedure or service to a different New Technology APC that most appropriately reflects its cost.

The procedures presented below represent services assigned to New Technology APCs for CY 2006 for which we believe we have sufficient data to reassign them to clinically appropriate APCs for CY 2007. Therefore, we are proposing to reassign them to clinically appropriate APCs as indicated specifically in our discussion and in Table 10.

a. Nonmyocardial Positron Emission Tomography (PET) Scans

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

We last proposed changes in payments for nonmyocardial PET procedures for CY 2005. At that time, while we had large numbers of single claims reflecting that the median cost of PET procedures was substantially lower than their CY 2004 payment rate of $1,450, we had some concerns that abruptly lowering the payment rate for nonmyocardial PET scans could hinder access to this technology. Therefore, we proposed three options to develop the CY 2005 payment rate for these procedures in the August 16, 2004 proposed rule (69 FR 50468). Specifically, we proposed the following options and invited comments on each of the options.

- Option 1: Continue in CY 2005 the CY 2004 assignment of the scans to New Technology APC 1516 prior to assigning to a clinical APC.
- Option 2: Assign the PET scans to a clinically appropriate APC priced according to the median cost of the scans based on CY 2003 claims data. Under this option, we would assign PET scans to APC 0420, PET imaging.
- Option 3: Transition assignment to a clinical APC in CY 2006 by setting payment in CY 2005 based on a 50/50 blend of the median cost of PET scans and their CY 2004 New Technology payment rate. We would assign the scans to New Technology APC 1513 for a blended transition payment.

Based on comments received, we decided to set the CY 2005 payment rate for nonmyocardial PET scans based on option 3 at $1,150. We further stated in the November 15, 2004 final rule with comment period (69 FR 65716) that we believed there were sufficient claims data to assign nonmyocardial PET scans to a single clinical APC. However, to minimize any potential impact that a payment reduction resulting from this move might have had on beneficiary access to this technology, we set the CY 2005 OPPS payment rate for nonmyocardial PET scans based on a 50/50 blend of their median cost based on CY 2003 claims data and the payment rate of the CY 2004 New Technology APC to which they were assigned. Therefore, nonmyocardial PET scans were assigned to New Technology APC 1513 (New Technology—Level XIV ($1,000-$1,200) for a blended payment rate of $1,150 in CY 2005. In CY 2005, in the context of an expansion in Medicare coverage for PET procedures, we also simplified coding for PET services by instructing hospitals to bill several more general CPT codes in place of numerous disease-specific G-codes. We continued with these coding and payment methodologies in CY 2006.

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

comparison to final claims for CY 2004 of approximately 121,000 for PET scans.

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

b. PET/Computed Tomography (CT) Scans

Since August 2000, we have paid separately for PET and CT scans. In CY 2004, the payment rate for nonmyocardial PET scans was $1,450, while it was $193 for typical diagnostic CT scans. Prior to CY 2005, nonmyocardial PET and the PET portion of PET/CT scans were described by G-codes for billing to Medicare. Several commenters to the November 15, 2004 final rule with comment period (69 FR 65682) urged that we replace the G-codes for nonmyocardial PET and PET/CT scan procedures with the established CPT codes. These commenters stated that movement to the established CPT codes would greatly reduce the burden on hospitals of tracking and billing the G-codes which are not recognized by other payers and would allow for more uniform hospital billing of these scans. We agreed with the commenters that movement from the G-codes to the established CPT codes for nonmyocardial PET and PET/CT scans would allow for more uniform billing of these scans. As a result of a Medicare national coverage determination (Publication 100–3, Medicare Claims Processing Manual section 220.6) that was made effective January 28, 2005, we discontinued numerous G-codes that described myocardial PET and nonmyocardial PET procedures and replaced them with the established CPT codes. The CY 2005 payment rate for concurrent PET/CT scans using the CPT codes 78814, 78815, and 78816 was $1,250, which was $100 higher than the payment rate for PET scans alone. These PET/CT CPT codes were placed in New Technology APC 1514 (New Technology—Level XIV, $1,200–$1,300) for CY 2005. We continued with these coding and payment methodologies in CY 2006.

For CY 2007, we are proposing the assignment of concurrent PET/CT scans, specifically CPT codes 78814, 78815, and 78816, to a clinically appropriate APC because we believe we have adequate claims data from CY 2005 upon which to determine the median cost of performing these procedures. Based on our analysis of CY 2005 single claims, the median cost of PET/CT scans is $865 from over almost 64,000 single claims. Comparison of the median cost of nonmyocardial PET procedures of $867 with the median cost of concurrent PET/CT scans demonstrates that the median costs of PET scans with or without concurrent CT scans for attenuation correction and anatomical localization are about the same. This result is not unexpected because many newer PET scanners also have the capability of rapidly acquiring CT images for attenuation correction and anatomical localization, sometimes with simultaneous image acquisition.

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

We note that we have been paying separately for fluorodeoxyglucose (FDG), the radiopharmaceutical described by HCPCS code A9552 (F18 fdg), that is commonly administered during nonmyocardial PET and PET/CT procedures. For CY 2007, we are proposing to continue paying separately for FDG, according to the methodology described in section V. (Proposed OPPS Payment Changes for Drugs, Biologicals, and Radiopharmaceuticals) of the preamble of this proposed rule.

c. Stereotactic Radiosurgery (SRS) Treatment Delivery Services

For the past several years, we have collected hospital costs associated with the planning and delivery of stereotactic radiosurgery services (hereafter referred to as SRS). As new technology emerged in the field of SRS, public commenters urged us to recognize cost differences associated with the various methods of SRS planning and delivery. Beginning in CY 2001, we established G-codes to capture any such cost variations associated with the various methods of planning and delivery of SRS. For CY 2004, based on comments received regarding the G-codes used for SRS, we made some modifications to the coding (68 FR 63431 and 63432). First, we received comments regarding the descriptors for HCPCS codes G0173 and G0251, indicating that these codes did not distinguish image-guided robotic SRS systems from other forms of linear accelerator-based SRS systems to account for the cost variation in delivering these services. In response, for CY 2004 we created two new G-codes (G0339 and G0340) to describe complete and fractionated image-guided robotic linear accelerator-based SRS treatment. We placed HCPCS code G0339 in APC 1528 at a payment rate of $5,250, and HCPCS code G0340 in APC 1525 at a payment rate of $3,750. Second, we received comments on HCPCS code G0242 which requested that we modify the code descriptor to avoid confusion and misuse of the code, and also to appropriately describe treatment planning for both linear accelerator-based and Cobalt 60-based SRS treatments. In response, for CY 2004, we created HCPCS code G0338 to distinguish linear accelerator-based SRS treatment planning from Cobalt 60-based SRS treatment planning. We placed HCPCS code G0338 in APC 1516 at a payment rate of $1,450.

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

continue to maintain HCPCS codes G0173, G0242, G0243, G0251, G0338, G0339, and G0340 in their respective New Technology APCs for CY 2005 as we considered the adoption of CPT codes to describe all SRS procedures for CY 2006.

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

Furthermore, the APC Panel recommended that we make no changes to the coding or APC placement of SRS treatment delivery HCPCS codes G0173, G0243, G0251, G0339, and G0340 for CY 2006. In addition, presenters to the APC Panel described ongoing deliberations among interested professional societies around the descriptions and coding for SRS. The APC Panel and presenters suggested that we wait for the outcome of these deliberations before making any significant changes to SRS delivery coding or payment rates. To date, we have received no report from participating professional societies as to the outcome of such deliberations.

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

Since we first established the full group of SRS treatment delivery codes in CY 2004, we now have 2 years of hospital claims data reflecting the costs of each of these services. Based on analysis of our claims data from CY 2004 and CY 2005, the median costs for linear accelerator-based SRS treatment delivery procedures as described by HCPCS codes G0173, G0251, G0339, and G0340 have been stable and generally lower than our New Technology APC payment rates in effect from CY 2004 through CY 2006. Specifically, the payment rate for HCPCS code G0173, a complete course of non-image guided, non-robotic linear accelerator-based SRS treatment, has been set at $5,250, yet our claims data indicate a median cost of $2,802 from CY 2004 claims and $3,665 from CY 2005 claims, based upon hundreds of single claims from each year. For HCPCS code G0251, fractionated non-image guided, non-robotic linear accelerator-based SRS treatment, the corresponding median costs have been $1,028 and $1,386 based upon over 1,000 single claims from each year, and relatively consistent with the procedure's New Technology APC payment of $1,150. With respect to the complete course of therapy in one session or first fraction of image-guided, robotic linear accelerator-based SRS, described by HCPCS code G0339, its median costs have been $4,917 and $4,809 for CY 2004 and CY 2005 respectively, based upon over 500 single bills in each year, in comparison with the procedure's payment rate of $5,250 for those years. Lastly, the median costs of HCPCS code G0340, the second through fifth sessions of image-guided, robotic linear accelerator-based SRS treatment, have been $2,502 for CY 2004 and $2,917 for CY 2005 as determined by over 1,000 single bills during each year, significantly lower than its payment rate of $3,750. Unquestionably, the claims data from CY 2004 and CY 2005 for linear accelerator-based SRS treatment delivery services reveal highly stable median costs from year to year based on significant claims volume.

Based on the above findings, we believe that we have adequate claims data to assign the SRS treatment delivery procedures to clinically appropriate APCs, and we believe that such movement is appropriate. For CY 2007, we are proposing to create several new SRS clinical APCs of different levels to assign the HCPCS codes describing linear accelerator-based SRS treatment, G0173, G0251, G0339, and G0340, based on their clinical and hospital resource similarities and differences. In particular, we are proposing to assign HCPCS codes G0339 and G0173 to the same Level III SRS APC, because we believe these codes that describe the complete or first fraction of all types of linear accelerator-based SRS treatments have substantial hospital resource and clinical similarity, as observed in their median costs and recognized previously in their equivalent New Technology APC payments. The codes describing subsequent fractions of image-guided, robotic and non-image guided, non-robotic linear accelerator-based SRS treatments will each be assigned to their own clinical APCs, as they demonstrate significant differences in resource utilization as reflected in their median costs. Their previous assignments to different New Technology APCs anticipated these resource distinctions. We are proposing to continue our assignment of HCPCS code G0243 for Cobalt 60-based SRS treatment delivery to clinical APC 0127, renamed Level IV Stereotactic Radiosurgery. Our proposed reassignments of SRS services from New Technology APCs to clinical APCs are listed in Table 8 below.

TABLE 8.—PROPOSED APC REASSIGNMENT FOR SRS TREATMENT DELIVERY SERVICES FOR CY 2007

HCPCS code	Short descriptor	CY 2006 SI	CY 2006 APC	CY 2006 payment rate	Proposed CY 2007 SI	Proposed CY 2007 APC	Proposed CY 2007 APC median cost
G0173	Linear acc stereo radsur com	S	1528	$5,250.00	S	0067	$4,059.61
G0251	Linear acc based stereo radio	S	1513	1,150.00	S	0065	1,386.20
G0339	Robot lin-radsurg com, first	S	1528	5,250.00	S	0067	4,059.61
G0340	Robot lin-radsurg fractx 2–5	S	1525	3,750.00	S	0066	2,916.68

d. Magnetoencephalography (MEG) Services

Magnetoencephalography (MEG) is a non-invasive diagnostic tool that assists surgeons presurgery by measuring and mapping brain activity. It may be used for epilepsy and brain tumor patients. Since CY 2002, the MEG procedures described by CPT codes 95965 (Meg, spontaneous), 95966 (Meg, evoked, single), and 95967 (Meg, evoked, each additional) have been assigned to New Technology APCs. In the July 25, 2005 proposed rule (70 FR 42709), we proposed to reassign MEG procedures to clinical APC 0430 using CY 2004 claims data to establish median costs on which the CY 2006 payment rates would be based. This proposal involved the reassignment of the three MEG procedures, specifically CPT codes 95965, 95966, and 95967, from three separate New Technology APCs into one new clinical APC with a status indicator of ''T.'' Commenters to this proposal believed that their assignment to clinical APC 0430 would be inappropriate because the proposed payment level of $674 was inadequate to cover the costs of the procedures, and because the procedures should not be assigned to only one level as their required hospital resources differ significantly. They further stated that our data did not represent the true costs of the procedures because MEG procedures are performed on very few Medicare patients.

Analysis of our hospital data for claims submitted from CY 2002 through CY 2005 indicates that these procedures are rarely performed on Medicare beneficiaries. For claims submitted from CY 2002 through CY 2005, our single claims data show that there were annually only between 2 and 23 claims submitted for CPT code 95965, 3 and 7 claims for CPT code 95966, and only 1 for CPT code 95967. Additionally, the hospital claims median costs for these codes have varied widely, perhaps due to our small volume of claims. The median cost for CPT code 95965 has ranged from $332 using CY 2002 claims to $3,166 based upon CY 2005 claims. The median cost for CPT code 95966 has varied widely from CY 2002 to CY 2005. For single claims submitted during CY 2002, the median cost was $1,949, while it was $507 for CY 2003, $1,435 for CY 2004, and $701 from 3 single claims for CY 2005. The median cost for CPT code 95967 based upon 1 single claim from CY 2005 claims is $217. We have no hospital median cost data for CPT code 95967 prior to CY 2005.

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

At the March 2006 APC Panel meeting, the Panel recommended that CMS move CPT codes 95965 (MEG, spontaneous), 95966 (MEG, evoked, single), and 95967 (MEG, evoked, each additional) from their CY 2006 New Technology APCs which were assigned based on the blended methodology described above to clinical APC(s) for CY 2007. Following that meeting, interested parties have provided us with CY 2005 charge and cost information from six hospitals that provided MEG services. These external data show wide variation in hospitals' costs and charges for MEG procedures, with generally higher values for CPT code 95965 and lower values for CPT codes 95966 and 95967 but no consistent proportionate relationship among those costs and charges. In some cases, the charges and costs for CPT codes 95966 and 95967 are quite similar for the two related services, one of which describes MEG for a single modality of evoked magnetic fields and the other that describes MEG for each additional modality of evoked magnetic fields. The individual hospital cost and charge data for specific services demonstrate significant variations of up to six fold across the hospitals, with an apparent inverse relationship between the numbers of services provided and the costs of the procedures. This finding is not unexpected, given the dependence of MEG procedures on the use of expensive capital equipment. As we have previously stated, our OPPS payment rates generally reflect the costs that are associated with providing care to Medicare beneficiaries in cost-efficient settings. For emerging technologies, we establish payment rates for new services that lack hospital claims data based on realistic utilization projections for all such services delivered in cost-efficient hospital outpatient settings. Given that we now have 4 years of hospital claims data for MEG procedures, because MEG is no longer a new technology, we do not believe these external data from 6 hospitals that performed MEG services in CY 2005 provide a better estimate of the hospital resources used in MEG procedures during the care of Medicare beneficiaries than our standard OPPS historical claims methodology.

We agree with the APC Panel and are proposing to accept their recommendation to move the MEG CPT codes into clinical APCs for CY 2007. While the volumes for the MEG procedures are low, almost all procedures, including those with very low Medicare volume, are assigned to clinical APCs under the OPPS, with their payment rates based on the median costs of their assigned APCs. Therefore, we are proposing to assign CPT code 95965 to new clinical APC 0038 (Spontaneous MEG) with a proposed median cost of $3,166.30 and to assign both CPT codes 95966 and 95967 to APC 0209 (Level II MEG, Extended EEG Studies, and Sleep Studies) with a proposed median cost of $709.36. We believe that the assignment of CPT codes 95966 and 95967 to APC 0209 is appropriate because MEG studies are similar to EEGs and sleep studies in measuring activity of the brain over a significant time period, and our hospital claims data show that their hospital resources are also relatively comparable. MEG procedures and their CY 2007 proposed APC assignments are displayed in Table 9.

TABLE 9.—PROPOSED CY 2007 APC ASSIGNMENT FOR MEG

HCPCS Code	Short descriptor	CY 2006 SI	CY 2006 APC	CY 2006 payment rate	Proposed CY 2007 SI	Proposed CY 2007 APC	Proposed CY 2007 APC median cost
95965	Meg, spontaneous	S	1523	$2,750.00	S	0038	$3,166.30
95966	Meg, evoked, single	S	1514	1,250.00	S	0209	709.36
95967	Meg, evoked, each additional	S	1510	850.00	S	0209	709.36

As these procedures are performed on very few Medicare patients, we expect to continue to have small Medicare claims volumes for MEG services each year. However, we are confident that over time our claims data for these procedures will become more consistent and reflective of the full hospital resources used in MEG services, especially because only a small subset of hospitals provide MEG services. We have been told that hospitals performing MEG procedure recently have been paying increased attention to accurately reporting charges for all necessary hospital resources on their claims. We are optimistic that both increased public awareness of Medicare coding for these procedures and improved understanding of the standard OPPS methodology for establishing APC payment rates should result in improved claims data in the future that more accurately reflect the required hospital resources.

e. Other Services in New Technology APCs

(If you choose to comment on issues in this section, please include the caption ''Other New Technology Services'' at the beginning of your comment.)

Other than the PET, PET/CT, and SRS new technology services discussed above, there are 23 procedures currently assigned to New Technology APCs for which we believe we also have data adequate to support their assignment to clinical APCs. For CY 2007, we are proposing to reassign these procedures to clinically appropriate APCs, applying their CY 2005 claims data to develop their clinical APC median costs on which payments would be based. These procedures and their proposed APC assignments are displayed in Table10.

TABLE 10.—PROPOSED APC REASSIGNMENT OF OTHER NEW TECHNOLOGY PROCEDURES TO CLINICAL APCS FOR CY 2007

HCPCS Code	Short descriptor	CY 2006 SI	CY 2006 APC	CY 2006 payment rate	Proposed CY 2007 SI	Proposed CY 2007 APC	Proposed CY 2007 APC median cost
0003T	Cervicography	S	1492	$15.00	T	0191	$9.22
0101T	Extracorp shockwv tx,hi enrg	T	1547	850.00	T	0050	1,548.05
0102T	Extracorp shockwv tx,anesth	T	1547	850.00	T	0050	1,548.05
0133T	Esophageal implant injexn	T	1556	1,750.00	T	0422	1,704.85
19296	Place po breast cath for rad	S	1524	3,250.00	T	0030	2,533.62
19297	Place breast cath for rad	S	1523	2,750.00	T	0029	1,822.38
20982	Ablate, bone tumor(s) perq	T	1557	1,850.00	T	0050	1,548.05
28890	High energy eswt, plantar f	T	1547	850.00	T	0050	1,548.05
36566	Insert tunneled cv cath	T	1564	4,750.00	T	0623	1,703.97
77421	Stereoscopic x-ray guidance	S	1502	75.00	S	0257	88.39
78804	Tumor imaging, whole body	S	1508	650.00	S	0408	308.82
79403	Hematopoietic nuclear tx	S	1507	550.00	S	0413	315.17
90473	Immune admin oral/nasal	S	1491	5.00	S	0436	10.71
90474	Immune admin oral/nasal addl	S	1491	5.00	S	0436	10.71
91035	G-esoph reflx tst w/electrod	S	1506	450.00	X	0361	242.86
C9716	Radiofrequency energy to anu	S	1519	1,750.00	T	0150	1,818.31
G0248	Demonstrate use home inr mon	S	1503	150.00	V	0604	49.45
G0249	Provide test material,equipm	S	1503	150.00	V	0604	49.45
G0293	Non-cov surg proc,clin trial	S	1505	350.00	X	0340	38.52
G0294	Non-cov proc, clinical trial	S	1502	75.00	X	0340	38.52
G0375	Smoke/tobacco counseling 3–10	S	1491	5.00	X	0031	10.60
G0376	Smoke/tobacco counseling >10	S	1491	5.00	X	0031	10.60
G3001	Admin + supply, tositumomab	S	1522	2,250.00	S	0442	1,515.80

D. Proposed APC-Specific Policies

1. Skin Replacement Surgery and Skin Substitutes (APCs 0024, 0025, 0027)

(If you choose to comment on issues in this section, please include the caption ''Skin Replacement Surgery and Skin Substitutes'' at the beginning of your comment.)

For CY 2006, the American Medical Association (AMA) made comprehensive changes, including code additions, deletions, and revisions, accompanied by new and revised introductory language, parenthetical notes, subheadings and cross-references, to the Integumentary, Repair (Closure) subsection of surgery in the CPT book to facilitate more accurate reporting of skin grafts, skin replacements, skin substitutes, and local wound care. In particular, the section of the CPT book previously titled ''Free Skin Grafts'' and containing codes for skin replacement and skin substitute procedures was renamed, reorganized, and expanded. New and existing CPT codes related to skin replacement surgery and skin substitutes were organized into five subsections: Surgical Preparation, Autograft/Tissue Cultured Autograft, Acellular Dermal Replacement, Allograft/Tissue Cultured Allogeneic Skin Substitute, and Xenograft.

As part of the CY 2006 CPT code update in the newly named ''Skin Replacement Surgery and Skin Substitutes'' section, certain codes were deleted that previously described skin allograft and tissue cultured and acellular skin substitute procedures, including CPT 15342 (Application of bilaminate skin substitute/neodermis; 25 sq cm); CPT 15343 (Application of bilaminate skin substitute/neodermis; each additional 25 sq cm); CPT 15350 (Application of allograft, skin; 100 sq cm or less), and CPT 15351 (Application of allograft, skin; each additional 100 sq cm). Thirty-seven new CPT codes were created in the ''Skin Replacement Surgery and Skin Substitutes'' section, and these codes received interim final status indicators and APC assignments in the CY 2006 final rule with comment period and were subject to comment.

At its March 2006 meeting, the APC Panel heard several presentations on some of the new CY 2006 CPT codes for skin replacement and skin substitute procedures, and CMS has received additional information from the public regarding a number of these services. In particular, 18 new CPT codes that were created to more specifically describe skin allograft, skin replacement, and skin substitute procedures were the subject of the APC Panel discussion and recommendations. These codes are as follows:

- CPT 15170 (Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT 15171 (Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof)
- CPT 15175 (Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT 15176 (Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof)
- CPT 15300 (Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT 15301 (Allograft skin for temporary wound closure; trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof)
- CPT 15320 (Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT 15321 (Allograft skin for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof)
- CPT 15340 (Tissue cultured allogeneic skin substitute; first 25 sq cm or less)
- CPT 15341 (Tissue cultured allogeneic skin substitute; each additional 25 sq cm)
- CPT 15360 (Tissue cultured allogeneic dermal substitute; trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT 15361 (Tissue cultured allogeneic dermal substitute; trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof)
- CPT 15365 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT 15366 (Tissue cultured allogeneic dermal substitute, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT 15420 (Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT 15421 (Xenograft skin (dermal), for temporary wound closure, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof)
- CPT 15430 (Acellular xenograft implant; first 100 sq cm or less, or one percent of body area of infants and children)
- CPT 15431 (Acellular xenograft implant; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof).

The CY 2006 interim final APC assignments of these codes, the recommendations made by the APC Panel at its March 2006 meeting, and our proposed placement of the codes for CY 2007 are listed in Table 11 below. Note that in general, biological skin substitutes and replacements used in procedures described by these CPT codes are proposed for separate payment under the OPPS for CY 2007, according to the methodology outlined in section V. of the preamble of this proposed rule.

TABLE 11.—CY 2007 PROPOSED ASSIGNMENTS OF SKIN SUBSTITUTE AND SKIN REPLACEMENT PROCEDURES

CPT code	Short descriptor	CY 2006 assignment			APC panel recommendation	CY 2007 proposed assignment		
		APC	SI	APC median		APC	SI	APC median
15170	Cell graft trunk/arm/legs	24	T	$92.22	27	25	T	$314.58
15171	Cell graft t/arm/leg add-on	24	T	92.22	25	25	T	314.58
15175	Acellular graft, f/n/hf/g	24	T	92.22	27	25	T	314.58
15176	Acell graft, f/n/hf/g/add-on	24	T	92.22	25	25	T	314.58
15300	Apply skin allograft, t/arm/lg	27	T	1081.66	N/A	25	T	314.58
15301	Apply sknallograft t/a/l addl	25	T	315.37	N/A	25	T	314.58
15320	Apply skin allogrft f/n/hf/g	25	T	315.37	27	25	T	314.58
15321	Apply sknallogrft f/n/hfg add	25	T	315.37	25	25	T	314.58
15340	Apply cult skin substitute	24	T	92.22	27	25	T	314.58
15341	Apply cult skin sub add-on	24	T	92.22	25	25	T	314.58
15360	Apply cult derm sub, t/a/l	24	T	92.22	27	25	T	314.58

TABLE 11.—CY 2007 PROPOSED ASSIGNMENTS OF SKIN SUBSTITUTE AND SKIN REPLACEMENT PROCEDURES—Continued

CPT code	Short descriptor	CY 2006 assignment			APC panel recommendation	CY 2007 proposed assignment		
		APC	SI	APC median		APC	SI	APC median
15361	Aply cult derm sub t/a/l/ add-on	24	T	92.22	25	25	T	314.58
15365	Apply cult derm sub f/n/hf/g	24	T	92.22	27	25	T	314.58
15366	Apply cult derm f/hf/g add	24	T	92.22	25	25	T	314.58
15420	Apply skin xgraft, f/n/hf/g	25	T	315.37	27	25	T	314.58
15421	Apply skn xgraft, f/n/hf/g add	25	T	315.37	25	25	T	314.58
15430	Apply acellular xenograft	25	T	315.37	27	25	T	314.58
15431	Apply acellular xgraft add	25	T	315.37	25	25	T	314.58

We reviewed the presentations to the APC Panel; the APC Panel's recommendations; the CPT code descriptors, introductory explanations, cross-references, and parenthetical notes; the clinical characteristic of the procedures; and the code-specific median costs for all related CPT codes available from our CY 2005 claims data. While we agree with the APC Panel that the codes currently placed in APC 0024 (Level I Skin Repair) should be assigned to an APC with a higher median cost for CY 2007, we disagree that these procedures should be placed in APC 0027 (Level IV Skin Repair). APC Panel presenters reasoned that some of the codes (CPTs 15170, 15175, 15320, 15340, 15360, 15365, 15420, and 15430) for the first increment of body surface area treated should be placed in APC 0027 because they are similar to CPT code 15300 (Allograft skin for temporary wound closure, trunk, arms, legs; first 100 sq cm or less, or one percent of body area of infants and children). Upon further review of the clinical and expected hospital resource characteristics of CPT code 15300, we believe that this procedure is not appropriately placed in APC 0027. Split-thickness and full thickness skin autograft procedures currently assigned to APC 0027 are likely to require greater hospital resources, including additional operating room time and special equipment, in comparison to application of a separately paid allograft skin product. Instead, for CY 2007 we are proposing to reassign CPT code 15300 to APC 0025 (Level II Skin Repair), with an APC median cost of $314.58. We agree, in principle, that other CPT codes for the first increment of body surface area treated with a skin replacement or skin substitute are similar clinically and from a hospital resource perspective to CPT code 15300 and are, therefore, proposing to assign these procedures to APC 0025 as well for CY 2007.

Similarly, presenters reasoned that the related add-on codes (CPTs 15171, 15176, 15321, 15342, 15361, 15366, 15421, and 15431) for procedures to treat additional body surface areas are similar to CPT code 15301 (Allograft skin for temporary wound closure, trunk, arms, legs; each additional 100 sq cm, or each additional one percent of body area of infants and children, or part thereof) in terms of required hospital resources. CPT code 15301 is assigned to APC 0025 for CY 2006. We are proposing to maintain the assignment of CPT code 15301 to APC 0025 for CY 2007 and to reassign the other add-on codes to this APC. Note that APC 0025 has a status indicator of ''T,'' so that the add-on codes will experience the standard OPPS multiple surgical procedure reduction when properly billed with the first body surface area treatment codes that are assigned to the same clinical APC. We believe that this reduction in payment for the procedural resources associated with the add-on services is appropriate.

2. Treatment of Fracture/Dislocation (APC 0046)

(If you choose to comment on issues in this section, please include the caption ''Treatment of Fracture/Dislocation'' at the beginning of your comment.)

APC 0046 is a large clinical APC to which many procedures related to the percutaneous or open treatment of fractures and dislocations are assigned for CY 2006. Most of the approximately 100 procedures in the APC are relatively low volume, with even fewer single bills available for ratesetting. The median costs of the significant procedures in this APC as configured for CY 2006 range from a low of about $1,415 to a high of about $3,893. We received comments to the CY 2006 proposed rule (70 FR 42674) requesting that we distinguish procedures containing ''with or without external fixation'' in their descriptors to provide greater payments when external fixation is used to treat fractures. The commenters explained that when external fixation devices are used, the costs of the procedures increase, and, therefore, the current APC placement significantly underpays those procedures in those instances. In the CY 2006 final rule with comment period (70 FR 68607), we declined to reassign procedures that could include external fixation at that time but we acknowledged that we had treated APC 0046 as an exception to the 2 times rule for several years. For CY 2006, we again treated APC 0046 as an exception to the 2 times rule, but noted we would ask the APC Panel to consider whether this APC could be reconfigured to improve its clinical and resource homogeneity.

At the March 2006 meeting of the APC Panel, we asked the Panel to consider a possible reconfiguration of APC 0046 based on partial year CY 2005 claims data. The reconfiguration would create three new APCs and would divide the codes in APC 0046 among them. The APC Panel recommended that CMS continue to evaluate the refinement of APC 0046 (Open/Percutaneous Treatment Fracture or Dislocation) into at least three APC levels, with consideration of a fourth level should data support this additional level. We are accepting the APC Panel's recommendation and are proposing for CY 2007 to split APC 0046 into three new APCs: APC 0062 (Level I Treatment Fracture/Dislocation); APC 0063 (Level II Treatment Fracture/Dislocation); and APC 0064 (Level III Treatment Fracture/Dislocation). To ensure clinical and resource homogeneity in the new APCs, their proposed configurations are based on the procedure code descriptors, clinical considerations specific to each procedure, and service-specific hospital resource utilization as shown in the claims data from CY 2005. Restructuring APC 0046 into these three new APCs eliminates 2 times rule violations in the Fracture/Dislocation series.

We are not currently proposing a fourth APC level in the Fracture/Dislocation series because we do not believe our claims data are sufficiently robust and consistent from year to year to support differential payment for another service level. One code, CPT 27615 (Radical resection of tumor (e.g., malignant neoplasm), soft tissue of leg or ankle area), is not clinically coherent with the other procedures in APC 0046, and we are proposing to reassign this procedure outside of the Fracture/Dislocation series to APC 0050 (Level II Musculoskeletal Procedures Except Hand and Foot) for CY 2007.

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Table 12.-- Reconfiguration of APC 0046

HCPCS Code	Description	Proposed APC
21336	Treat nasal septal fracture	0063
21805	Treatment of rib fracture	0062
23515	Treat clavicle fracture	0064
23530	Treat clavicle dislocation	0063
23532	Treat clavicle dislocation	0062
23550	Treat clavicle dislocation	0063
23552	Treat clavicle dislocation	0063
23585	Treat scapula fracture	0064
23615	Treat humerus fracture	0064
23616	Treat humerus fracture	0064
23630	Treat humerus fracture	0064
23660	Treat shoulder dislocation	0063
23670	Treat dislocation/fracture	0064
23680	Treat dislocation/fracture	0063
24515	Treat humerus fracture	0064
24516	Treat humerus fracture	0064
24538	Treat humerus fracture	0062
24545	Treat humerus fracture	0064
24546	Treat humerus fracture	0064
24566	Treat humerus fracture	0062
24575	Treat humerus fracture	0064
24579	Treat humerus fracture	0064
24582	Treat humerus fracture	0062
24586	Treat elbow fracture	0064
24587	Treat elbow fracture	0064
24615	Treat elbow dislocation	0064

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HCPCS Code	Description	Proposed APC
24635	Treat elbow fracture	0064
24665	Treat radius fracture	0063
24666	Treat radius fracture	0064
24685	Treat ulnar fracture	0063
25515	Treat fracture of radius	0063
25525	Treat fracture of radius	0063
25526	Treat fracture of radius	0063
25545	Treat fracture of ulna	0063
25574	Treat fracture radius & ulna	0064
25575	Treat fracture radius/ulna	0064
25611	Treat fracture radius/ulna	0062
25620	Treat fracture radius/ulna	0064
25628	Treat wrist bone fracture	0063
25645	Treat wrist bone fracture	0063
25651	Pin ulnar styloid fracture	0062
25652	Treat fracture ulnar styloid	0063
25670	Treat wrist dislocation	0062
25671	Pin radioulnar dislocation	0062
25676	Treat wrist dislocation	0062
25685	Treat wrist fracture	0062
25695	Treat wrist dislocation	0062
26608	Treat metacarpal fracture	0062
26615	Treat metacarpal fracture	0063
26650	Treat thumb fracture	0062
26665	Treat thumb fracture	0063
26676	Pin hand dislocation	0062
26685	Treat hand dislocation	0063
26686	Treat hand dislocation	0064
26715	Treat knuckle dislocation	0063
26727	Treat finger fracture, each	0062
26735	Treat finger fracture, each	0063
26746	Treat finger fracture, each	0063
26756	Pin finger fracture, each	0062
26765	Treat finger fracture, each	0063
26776	Pin finger dislocation	0062
26785	Treat finger dislocation	0062
27202	Treat tail bone fracture	0063
27509	Treatment of thigh fracture	0062
27524	Treat kneecap fracture	0063
27566	Treat kneecap dislocation	0063
27615	Remove tumor, lower leg	0050
27756	Treatment of tibia fracture	0062
27758	Treatment of tibia fracture	0063
27759	Treatment of tibia fracture	0064
27766	Treatment of ankle fracture	0063
27784	Treatment of fibula fracture	0063
27792	Treatment of ankle fracture	0063
27814	Treatment of ankle fracture	0063
27822	Treatment of ankle fracture	0063

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HCPCS Code	Description	Proposed APC
27823	Treatment of ankle fracture	0064
27826	Treat lower leg fracture	0063
27827	Treat lower leg fracture	0064
27828	Treat lower leg fracture	0064
27829	Treat lower leg joint	0063
27832	Treat lower leg dislocation	0063
27846	Treat ankle dislocation	0063
27848	Treat ankle dislocation	0063
28406	Treatment of heel fracture	0062
28415	Treat heel fracture	0063
28420	Treat/graft heel fracture	0063
28436	Treatment of ankle fracture	0062
28445	Treat ankle fracture	0063
28456	Treat midfoot fracture	0062
28465	Treat midfoot fracture, each	0063
28476	Treat metatarsal fracture	0062
28485	Treat metatarsal fracture	0063
28496	Treat big toe fracture	0062
28505	Treat big toe fracture	0063
28525	Treat toe fracture	0063
28531	Treat sesamoid bone fracture	0063
28545	Treat foot dislocation	0062
28546	Treat foot dislocation	0062
28555	Repair foot dislocation	0063
28576	Treat foot dislocation	0062
28585	Repair foot dislocation	0063
28606	Treat foot dislocation	0062
28615	Repair foot dislocation	0063
28636	Treat toe dislocation	0062
28645	Repair toe dislocation	0063
28666	Treat toe dislocation	0062
28675	Repair of toe dislocation	0063

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3. Electrophysiologic Recording/Mapping (APC 0087)

(If you choose to comment on issues in this section, please include the caption ''Electrophysiologic Recording/Mapping'' at the beginning of your comment.)

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

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

4. Insertion of Mesh or Other Prosthesis (APC 0154)

(If you choose to comment on issues in this section, please include the caption ''Insertion of Mesh or Other Prosthesis'' at the beginning of your comment.)

During the March 2006 APC Panel meeting, a presenter requested that we

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

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

In the CY 2005 claims data, the median cost for CPT code 57267 is $529.14, the lowest by far for procedures in APC 0154, which has an APC median cost of $1,821 for CY 2007. However, the median cost of CPT code 57267 is based on only 6 single claims of the total 1,038 submitted for the service. Because the procedure always is performed in addition to other related procedures, we expect that claims for this service will be multiple claims. Therefore, we are not confident that the procedure's median cost based upon the six single claims is accurate.

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

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

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

TABLE 13.—MEDIAN COSTS OF HCPCS CODE C1781 AND ASSOCIATED PROCEDURES

HCPCS code	Short descriptor	Line-item median cost	Single claims median cost	CY 2006 APC 0154 payment amount (T status)
57267	Insert mesh/pelvic flr add-on	$423.28	$529.14	$1,704.59
C1781 (billed with 57267)	Mesh (implantable)	383.35	N/A	N/A
49568	Hernia repair w/mesh	363.41	1,323.29	1,704.59
C1781 (billed with 49568)	Mesh (implantable)	242.20	N/A	N/A

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

5. Percutaneous Renal Cryoablation (APC 0163)

(If you choose to comment on issues in this section, please include the caption ''Percutaneous Renal Cryoablation'' at the beginning of your comment.)

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

The APC Panel recommended that we assign CPT code 0135T to APC 0423 for CY 2007.

CPT code 0135T is new for CY 2006 and therefore, we have no claims data on which to base our APC assignment decision. The procedure currently has an interim assignment to APC 0163 (Level IV Cystourethroscopy and Other Genitourinary Procedures), with a CY 2006 payment amount of $1,999.35.

We are proposing to accept the APC Panel's recommendation to reassign CPT code 0135T to APC 0423 for CY 2007. We believe that assignment of CPT code 0135T to APC 0423 is clinically appropriate, and that the CY 2007 median cost of APC 0423 of $2,410 is reasonably close to our expectations regarding the resource requirements for the renal cryoablation procedure.

6. Keratoprosthesis (APC 0244)

(If you choose to comment on issues in this section, please include the caption ''Keratophrosthesis'' at the beginning of your comment.)

CPT code 65770 is a surgical procedure for implantation of a keratoprosthesis, an artificial cornea. The keratoprosthesis device that is required for the implantation is described by HCPCS code C1818 (Integrated keratoprosthesis), a device category that received transitional pass-through payment under the OPPS from July 2003 through December 2005. When the device came off pass-through status for CY 2006 and its costs were packaged into the implantation procedure, CPT code 65770 continued to be assigned to APC 0244 (Corneal Transplant), with a payment rate of about $2,275, despite an increase in the median cost of the implantation procedure of about $1,200 associated with the packaging of the device. There is no 2 times violation in APC 0244 for CY 2006.

At the March 2006 meeting of the APC Panel, following a presentation regarding the procedure to implant a keratoprosthesis that described the clinical and hospital resource characteristics of CPT code 65770, the Panel recommended moving CPT code 65770 to a more appropriate APC in order to make appropriate payment. We agree with the recommendation of the APC Panel. Claims data from CY 2005 demonstrate that the median cost for implantation of a keratoprosthesis of $3,127.51 remains significantly higher than the median costs of other procedures assigned to APC 0244, although there is no 2 times violation. In addition, CPT code 65770 contributes less than 1 percent of the single claims in the APC available for ratesetting, and it is likely to continue to be an uncommon procedure among Medicare beneficiaries, resulting in its persistent small contribution to the median cost of APC 0244. Therefore, for CY 2007 we are proposing to create a new APC 0293 (Level V Anterior Segment Eye Procedures) with a median cost of $3,127.51 and to move CPT code 65770 into that APC in order to more appropriately pay for the procedure and the related device.

7. Medication Therapy Management Services

(If you choose to comment on issues in this section, please include the caption ''Medication Therapy Management Services'' at the beginning of your comment.)

Following a presentation at its March 2006 meeting, the APC Panel made two recommendations regarding Category III CPT codes for pharmacist medication therapy management services that were new for CY 2006. These services include CPT codes 0115T (medication therapy management services provided by a pharmacist, individual, face-to-face with patient, initial 15 min., w/assessment and intervention if provided; initial encounter), 0116T (medication therapy management; subsequent encounter), and 0117T (medication therapy management; additional 15 min.). These codes were assigned status indicator ''B'' in the CY 2006 OPPS final rule with comment period, indicating that they are not recognized by the OPPS when submitted on an outpatient hospital Part B bill type, with comment indicator ''NI'' to identify them as subject to comment. The APC Panel recommended that we create a new APC, with a nominal payment, to which we would assign these codes; implement the assignment in July 2006, if possible, or otherwise in CY 2007; and provide guidance to hospitals on how and when these codes should be reported. We are not accepting the APC Panel's recommendations. Rather, we are proposing to continue to assign status indicator ''B'' to CPT codes 0115T, 0116T, and 0117T for CY 2007.

According to the AMA, the purpose of Category III CPT codes is to facilitate data collection on and assessment of new services and procedures. Medication therapy management services are not new services in the OPPS, as they have been provided to patients by hospitals in the past as components of a wide variety of services provided by hospitals, including clinic and emergency room visits, procedures, and diagnostic tests. As such, we believe their associated hospital resource costs are already incorporated into the OPPS payments for these other services that are based on historical hospital claims data. The three Category III CPT codes specifically describe medication therapy management services provided by a pharmacist. We have no need to distinguish medication therapy management services provided by a pharmacist in a hospital from medication therapy management services provided by other hospital staff, as the OPPS only makes payments for services provided incident to physicians' services. Hospitals providing medication therapy management services incident to physicians' services may choose a variety of staffing configurations to provide those services, taking into account other relevant factors such as State and local laws and hospital policies.

In general, we do not establish new clinical APCs for new codes and set payment rates for those APCs when we have no cost data for any services populating the APCs. New codes where we believe that there are no existing clinical APCs compatible with their expected clinical and hospital resource characteristics are often assigned to New Technology APCs until we have sufficient cost data to determine appropriate clinical APC assignments. However, these medication therapy management codes would not be eligible to map to New Technology APCs because they are not new services which are unrepresented in historical hospital claims data. As stated earlier, because we believe the costs of medication therapy management services are imbedded as a component within our claims data, we are confident that our claims data reflect the costs of pharmacist medication management services provided to hospital outpatients who are receiving hospital services.

8. Complex Interstitial Radiation Source Application (APC 0651)

(If you choose to comment on issues in this section, please include the caption ''Complex Interstitial Radiation Source Application'' at the beginning of your comment.)

APC 0651 (Complex Interstitial Radiation Source Application), contains only one code, CPT code 77778 (Complex interstitial application of brachytherapy sources). The coding, APC assignment, median cost, and resulting payment rate for CPT code 77778 have not been stable since the inception of the OPPS, and that instability has been a source of concern to hospitals that furnish the service and to specialty societies. The vast majority

of claims for interstitial brachytherapy are for the treatment of patients with a diagnosis of prostate cancer. The historical coding, APC assignments, and payment rates for CPT code 77778 and the related service CPT code 55859 (Transperitoneal placement of needles or catheters into the prostate for application of brachytherapy sources), are shown in Table 14.

TABLE 14.—HISTORICAL PAYMENT RATES FOR COMPLEX INTERSTITIAL APPLICATION OF BRACHYTHERAPY SOURCES

OPPS CY	Combination APC	CPT code 77778	APC for 77778	CPT code 55859	APC for 55859	Source
2000	N/A	$198.31	APC 312	$848.04	APC 162	Pass-through.
2001	N/A	205.495	APC 312	878.72	APC 162	Pass-through.
2002	N/A	6344.67	APC 312	2068.23	APC 163	Pass-through with pro rata reduction.
2003 (if prostate brachytherapy with iodine sources).	G0261, APC 648, $5154.34.	N/A	N/A	N/A	N/A	Packaged.
2003 (if prostate brachytherapy with palladium sources).	G0256, APC 649, $5998.24.	N/A	N/A	N/A	N/A	Packaged.
2003 (if not prostate brachytherapy, not including sources).	N/A	2853.58	APC 651	1479.60	APC 163	Separate payment based on scaled median cost per source.
2004	N/A	558.24	APC 651	1848.55	APC 163	Cost.
2005	N/A	1248.93	APC 651	2055.63	APC 163	Cost.
2006	N/A	666.21	APC 651	1993.35	APC 163	Cost.

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

At the March 2006 APC Panel meeting, presenters urged the Panel to recommend that CMS use only single procedure claims that contain charges for brachytherapy sources on the same claim with CPT code 77778 to set the median cost for APC 0651. Presenters also urged that CMS adopt a process for using multiple procedure claims to set the median for APC 0651 that would sum the costs on multiple procedure claims containing CPT codes 77778 and 55859 (and no other separately payable services not on the bypass list) and, excluding the costs of sources, split the resulting aggregate median cost on the multiple procedure claim according to a preestablished attribution ratio between CPT codes 77778 and 55859. Presenters also urged that we provide hospital education on correct coding of brachytherapy services and devices of brachytherapy required to perform brachytherapy procedures. They indicated that any claim for a brachytherapy service that did not also report a brachytherapy source should be considered to be incorrectly coded and thus not reflective of the hospital resources required for the interstitial source application procedure. They believed that these claims should be excluded from use in establishing the median cost for APC 0651. They believed that hospitals which report the brachytherapy sources on their claims are more likely to report complete charges for the associated brachytherapy procedure than hospitals that do not report the separately payable brachytherapy sources.

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

In response to the APC Panel recommendations, we are explicitly analyzing the standard OPPS methodology that we used in determining our proposed payment rate for APC 0651 in this proposed rule in the context of alternative multiple bill methodologies. In addition, we note that we routinely accept requests from interested organizations to discuss their views about OPPS payment policy issues.

The organizations that the APC Panel asked us to work with have frequently brought their concerns to our attention through the rulemaking process and otherwise. We will consider the input of any individual or organization to the extent allowed by Federal law including the Administrative Procedure Act (APA) and the Federal Advisory Committee Act (FACA). We establish the OPPS rates through regulations. We are required to consider the timely comments of interested organizations, establish the payment policies for the forthcoming year, and respond to the timely comments of all public commenters in the final rule in which we establish the payments for the forthcoming year.

For this proposed rule, we developed a median cost for APC 0651 using single procedure claims using the general OPPS process, but we also looked at multiple procedure claims that contain the most common combinations of codes used with APC 0651. Our single procedure claims process results in using 1,123 claims to calculate a median cost of $1028.93 for APC 0651. We have added CPT code 76965, a CPT code for ultrasound guidance that commonly appears on claims for complex

interstitial brachytherapy, to the bypass list for CY 2007 after close clinical review because we believe that it would typically have little associated packaging. We believe that this change, along with maintenance of CPT code 77290 for complex therapeutic radiology simulation-aided field setting on the bypass list, is responsible for the growth in single procedure claims from the 381 single bills on which the APC 0651 median cost was calculated for the CY 2006 OPPS final rule with comment period. However, only 6 of these 1,123 single and ''pseudo'' single claims also included brachytherapy sources used in complex interstitial brachytherapy source application, and the median cost for these 6 claims at $600.68 is significantly less than the median cost for all single claims. It is unclear why so many of these claims do not contain brachytherapy sources, which were separately paid at cost in CY 2005. Because we are proposing to pay separately for brachytherapy sources again for CY 2007, we see no reason to believe that these few claims for brachytherapy services that included sources, which also do not report CPT code 55859 for placement of needles or catheters into the prostate, are more correctly coded than those claims which do not separately report brachytherapy sources. We believe it is possible that hospitals billing CPT code 77778 and not the associated brachytherapy sources may have bundled their charges for the brachytherapy sources into their charge for CPT code 77778.

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

We found 10,571 multiple procedure claims with CPT codes 55859 and 77778 reported on the claim, including those both with and without separately reported sources. We found that 7,181 of the 10,571 claims contained any combination of the 3 ancillary codes (76000, 76965, or 77290). Table 15 shows the results of bypassing and packaging the line-item costs of the 3 ancillary procedures.

TABLE 15.—MULTIPLE PROCEDURE CLAIMS INCLUDING CPT CODES 55859 AND 77778

	Frequency	Minimum cost	Maximum cost	Mean cost	Median cost
Ancillary Codes Packaged	*7180	$828.46	$11,202.81	$3,326.50	$3,062.99
Ancillary Codes Bypassed	7181	811.95	11,203.81	3,300.16	3,030.01

*1 lost to trimming.

We found 9,791 multiple procedure claims with CPT codes 55859 and 77778 reported on the claim that also included brachytherapy sources that would be used with CPT code 77778. We found that 6,748 of the 9,791 claims contained any combination of the 3 ancillary codes. Table 16 shows the results of bypassing and packaging the line-item costs of the 3 ancillary procedures.

TABLE 16.—MULTIPLE PROCEDURE CLAIMS INCLUDING CPT CODES 55859 AND 77778 AND ONE OR MORE BRACHYTHERAPY SOURCES

	Frequency	Minimum cost	Maximum cost	Mean cost	Median cost
Ancillary Codes Packaged	6748	$890.56	$10,224.17	$3,240.13	$3,026.62
Ancillary Codes Bypassed	6748	912.81	10,307.37	3,215.75	2,992.60

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

Moreover, when we calculate the total median cost from single bills for the APCs for the two major procedures codes without regard to the separate payments that would be made for CPT codes 76000, 76965, and 77290, the sum of the CY 2007 proposed medians for APC 0651 and APC 0163 is $3,197.07, which is greater than the combination medians, even when the three ancillary services are packaged into the combination median. Under our proposed policies for CY 2007, hospitals would also be paid separately for brachytherapy sources, guidance services, and radiation therapy planning services that may be provided in support of services reported with CPT codes 55859 and 77778.

Therefore, we believe that the summed median cost for APC 0651 and APC 0163 results in an appropriate level of full payment for the dominant type of service provided under APC 0651, interstitial prostate brachytherapy. We are proposing to use the median cost of $1,028.93, as derived from all single bills for APC 0651 according to our standard OPPS methodology, to establish the median for that APC.

We recognize that prostate brachytherapy is not the sole use of CPT code 77778, although it is the predominant use. Costs attributable to the placement of needles and catheters and to the interstitial application of brachytherapy sources to sites other than the prostate may also be reported on claims whose data map to APC 0651.

This clinically driven variability in the claims data is difficult to assess without adding additional levels of complexity to the issue by considering diagnoses in establishing payments rates. However, recognizing that a PPS is a system based on averages and, to the extent that claims for all types of complex interstitial brachytherapy source application are included in the body of claims used to set the median cost for APC 0651, we believe that the payment for these services is appropriate.

9. Single Allergy Tests (APC 0381)

(If you choose to comment on issues in this section, please include the caption ''Allergy Testing'' at the beginning of your comment.)

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 2007. Multiple allergy tests are assigned to APC 0370, with a median cost calculated based on the standard OPPS methodology. We provided billing guidance in CY 2006 in Transmittal 804 (issued on January 3, 2006) specifically clarifying that hospitals should report charges for the CPT codes that describe single allergy tests to reflect charges ''per test'' rather than ''per visit'' and should bill the appropriate number of units of these CPT codes to describe all of the tests provided. However, our CY 2005 claims data available for the CY 2007 proposed rule do not yet reflect the improved and more consistent hospital billing practices of ''per test'' ''for single allergy tests. Some claims for single allergy tests still appear to provide charges that represent a ''per visit'' charge, rather than a ''per test'' charge. Therefore, consistent with our payment policy for CY 2006, we are proposing to calculate a ''per unit'' median cost for APC 0381, based upon 349 claims containing multiple units or multiple occurrences of a single CPT code, where packaging on the claims is allocated equally to each unit of the CPT code. Using this methodology, we are proposing a median cost of $13.29 for APC 0381 for CY 2007. We are hopeful that the better and more accurate hospital reporting and charging practices for these single allergy test CPT codes beginning in CY 2006 will allow us to calculate the median cost of APC 0381 using the standard OPPS process in future OPPS updates.

10. Hyperbaric Oxygen Therapy (APC 0659)

(If you choose to comment on issues in this section, please include the caption ''Hyperbaric Oxygen Therapy'' at the beginning of your comment.)

When hyperbaric oxygen therapy (HBOT) is prescribed for promoting the healing of chronic wounds, it typically is prescribed for 90 minutes and billed using multiple units of HBOT on a single line or multiple occurrences of HBOT on a claim. In addition to the therapeutic time spent at full hyperbaric oxygen pressure, treatment involves additional time for achieving full pressure (descent), providing air breaks to prevent neurological and other complications from occurring during the course of treatment, and returning the patient to atmospheric pressure (ascent). The OPPS recognizes HCPCS code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval) for HBOT provided in the hospital outpatient setting.

In the CY 2005 final rule with comment period (69 FR 65758 through 65759), we finalized a ''per unit'' median cost calculation for HBOT 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 cost-to-charge ratio (CCR) to estimate costs for HCPCS code C1300 from billed charges rather than the CCR for the respiratory therapy cost center. Comments on the CY 2005 proposed rule effectively demonstrated that hospitals report the costs and charges for HBOT in a wide variety of cost centers. We used this methodology to estimate payment for HBOT in CYs 2005 and 2006. For CY 2007, we are proposing to continue using the same methodology to estimate a ''per unit'' median cost for HCPCS code C1300. Using 50,311 claims with multiple units or multiple occurrences, we estimate a median cost of $98.36.

11. Myocardial Positron Emission Tomography (PET) Scans (APCs 0306, 0307)

(If you choose to comment on issues in this section, please include the caption ''Myocardial PET Scans'' at the beginning of your comment.)

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

Analysis of the latest CY 2005 claims data for myocardial PET scans reveals that the APC median costs for the single and multiple myocardial PET codes are $836 and $680 respectively, based on 296 single claims for single studies and 1,150 single claims for multiple scan procedures. Despite more CY 2005 single claims for multiple scan procedures, the median cost of these procedures declined significantly from CY 2004 to CY 2005, dropping below the median cost of single studies. As indicated earlier, there was a significant coding change for myocardial PET services in CY 2005, with the reporting

of a single CPT code for multiple studies (CPT code 78492) for most of CY 2005, in comparison with nine G-codes in CY 2004. We examined the single bills for multiple scan procedures from CY 2004 and noted 17 hospitals were represented, with the majority of those claims from a single hospital. In contrast, in the CY 2005 claims, 25 hospitals were represented in the single bills for multiple scan procedures, and no single hospital contributed a majority of claims to the median cost calculation. We also examined differences in charges associated with G-codes versus the CPT code to determine if hospitals had adjusted the charge for the CPT code to reflect the termination of the multiple study G-codes. However, the individual charging practices of hospitals did not appear to vary with the use of a G-code versus the CPT code in either the CY 2004 or the CY 2005 claims. Greater volume of claims and consistent charging for both the G-codes and CPT code by hospitals suggest that the median appropriately captures the greater variability in relative hospital costs for multiple myocardial PET studies in the CY 2005 claims data.

Based on our claims data, the use of myocardial PET scan technology has become more widely prevalent in hospitals, and as a result, we now have more data to support our proposed payment rates. We believe that the median costs from our CY 2005 claims data for myocardial PET scan services, calculated based upon our standard OPPS methodology and based on almost 1,500 single claims, for both the single and multiple scans, should be reflective of the hospital resources required to provide the services to Medicare beneficiaries in the outpatient hospital setting. Based on these data, the differential median costs of the single and multiple study procedures do not support the present two-level APC payment structure. Although we acknowledge that some people may believe that multiple scan procedures should require increased resources at some hospitals in comparison with single scans, particularly because of the longer scan times required for multiple studies, our data do not support a resource differential that would necessitate the placement of these single and multiple scan procedures into two separate APCs. As myocardial PET scans are being provided more frequently at a greater number of hospitals than in the past, it is possible that most hospitals performing multiple PET scans are particularly efficient in their delivery of higher volumes of these services and, therefore, incur hospital costs that are similar to those of single scans, which are provided less commonly.

When all myocardial PET scan procedure codes are combined into a single clinical APC, as they were prior to CY 2006, the APC median cost for myocardial PET services is about $721, very similar to the $703 median cost of their single CY 2005 clinical APC. Therefore, for CY 2007, we are proposing to assign CPT codes 78459, 78491, and 78492 to a single APC, specifically, APC 0307 titled Myocardial Positron Emission Tomography (PET) Imaging, with a proposed median cost of $721. We believe that the assignment of these three CPT codes to APC 0307 is appropriate as the CY 2005 claims data reveal that more hospitals are providing multiple myocardial PET scan services, most myocardial PET scans are multiple studies, and the hospital resource costs of single and multiple studies are similar. We believe that the proposed median cost appropriately reflects the hospital resources associated with providing myocardial PET scans to Medicare beneficiaries in cost-efficient settings. Further, we believe that the proposed rates are adequate to ensure appropriate access to these services for Medicare beneficiaries. We are seeking comments on our proposal to provide a single payment rate for all myocardial PET scans in CY 2007. The myocardial PET scan CPT codes and their CY 2007 proposed APC assignments are displayed in Table 17.

TABLE 17.—PROPOSED CY 2007 APC ASSIGNMENT FOR MYOCARDIAL PET

HCPCS code	Short descriptor	CY 2006 SI	CY 2006 APC	CY 2006 payment rate	Proposed CY 2007 SI	Proposed CY 2007 APC	Proposed CY 2007 APC median cost
78459	Heart muscle imaging (PET)	S	0306	$800.55	S	0307	$721.26
78491	Heart image (PET), single	S	0306	800.55	S	0307	721.26
78492	Heart image (PET), multiple	S	0307	2,484.88	S	0307	721.26

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

(If you choose to comment on issues in this section, please include the caption ''Radiology Procedures'' at the beginning of your comment.)

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

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

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

rates to further refine these rates in the context of additional study findings.

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

With respect to the APC Panel's recommendation regarding the reporting of costs and charges for radiology services, CMS requires hospitals to report their costs and charges through the cost report with sufficient specificity to support CMS' use of cost report data for monitoring and payment. Within generally accepted principles of cost accounting, we allow providers flexibility to accommodate the unique attributes of each institution's accounting systems. For example, providers must match the generally intended meaning of the line-item cost centers, both standard and nonstandard, to the unique configuration of department and service categories used by each hospital's accounting system. Also, while the cost report provides recommended bases of allocation for the general services cost centers, a provider is permitted, within specified guidelines, to use an alternative basis for a general service cost if it can justify to its fiscal intermediary that the alternative is more accurate than the recommended basis. This approach creates internal consistency between a hospital's accounting system and the cost report, but cannot guarantee the precise comparability of costs and charges for individual cost centers across institutions.

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

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

IV. Proposed OPPS Payment Changes for Devices

A. Proposed Treatment of Device-Dependent APCs

(If you choose to comment on issues in this section, please include the caption ''Device-Dependent APCs'' at the beginning of your comment.)

1. Background

Device-dependent APCs are populated by HCPCS codes that usually, but not always, require that a device be implanted or used to perform the procedure. For the CY 2002 OPPS, we used external data, in part, to establish the device-dependent APC medians used for weight setting. At that time, many devices were eligible for pass-through payment. For the CY 2002 OPPS, we estimated that the total amount of pass-through payments would far exceed the limit imposed by statute. To reduce the amount of a pro rata adjustment to all pass-through items, we packaged 75 percent of the cost of the devices, using external data furnished by commenters on the August 24, 2001 proposed rule and information furnished on applications for pass-through payment, into the median costs for the device-dependent APCs associated with these pass-through devices. The remaining 25 percent of the cost was considered to be pass-through payment.

In the CY 2003 OPPS, we determined APC medians for device-dependent APCs using a three-pronged approach. First, we used only claims with device codes on the claim to set the medians for these APCs. Second, we used

external data, in part, to set the medians for selected device-dependent APCs by blending that external data with claims data to establish the APC medians. Finally, we also adjusted the median for any APC (whether device-dependent or not) that declined more than 15 percent. In addition, in the CY 2003 OPPS we deleted the device codes (''C'' codes) from the HCPCS file in the belief that hospitals would include the charges for the devices on their claims, notwithstanding the absence of specific codes for devices used.

In the CY 2004 OPPS, we used only claims containing device codes to set the medians for device-dependent APCs and again used external data in a 50/50 blend with claims data to adjust medians for a few device-dependent codes when it appeared that the adjustments were important to ensure access to care. However, hospital device code reporting was optional.

In the CY 2005 OPPS, which was based on CY 2003 claims data, there were no device codes on the claims and, therefore, we could not use device-coded claims in median calculations as a proxy for completeness of the coding and charges on the claims. For the CY 2005 OPPS, we adjusted device-dependent APC medians for those device-dependent APCs for which the CY 2005 OPPS payment median was less than 95 percent of the CY 2004 OPPS payment median. In these cases, the CY 2005 OPPS payment median was adjusted to 95 percent of the CY 2004 OPPS payment median. We also reinstated the device codes and made the use of the device codes mandatory where an appropriate code exists to describe a device utilized in a procedure. We also implemented HCPCS code edits to facilitate complete reporting of the charges for the devices used in the procedures assigned to the device-dependent APCs.

In the CY 2006 OPPS, which was based on CY 2004 claims data, we set the median costs for device-dependent APCs for CY 2006 at the highest of: (1) The median cost of all single bills; (2) the median cost calculated using only claims that contained pertinent device codes and for which the device cost is greater than $1; or (3) 90 percent of the payment median that was used to set the CY 2005 payment rates. We set 90 percent of the CY 2005 payment median as a floor rather than 85 percent as proposed, in consideration of public comments that stated that a 15-percent reduction from the CY 2005 payment median was too large of a transitional step. We noted in our CY 2006 proposed rule that we viewed our proposed 85-percent payment adjustment as a transitional step from the adjusted medians of past years to the use of unadjusted medians based solely on hospital claims data with device codes in future years (70 FR 42714). We also incorporated, as part of our CY 2006 methodology, the recommendation to base payment on medians that were calculated using only claims that passed the device edits. As stated in the CY 2006 OPPS final rule with comment period (70 FR 68620), we believed that this policy provided a reasonable transition to full use of claims data in CY 2007, which would include device coding and device editing, while better moderating the amount of decline from the CY 2005 OPPS payment rates.

2. Proposed CY 2007 Payment Policy

For CY 2007, we are proposing to base the device-dependent APC medians on CY 2005 claims, the most current data available. As stated earlier, in CY 2005 we reinstated the use of device codes and made the reporting of device codes mandatory where an appropriate code exists to describe a device utilized. In CY 2005, we also implemented HCPCS code edits to facilitate complete reporting of the charges for the devices used in the procedures assigned to the device-dependent APCs. We implemented the first set of device edits on April 1, 2005, for those APCs for which the CY 2005 payment rate was based on an adjusted median cost. We continued to take public comment on the remaining device edits after April 1, 2005, and implemented device edits for the remaining device-dependent APCs on October 1, 2005. Subsequent to the implementation of the device edits, we received public comments that caused us to remove the requirement for edits for several APCs on the basis that the services in them do not always require the use of a device or there may be no suitable device codes available for reporting all devices that may be used to perform the procedures.

For example, we removed the requirement for device codes for APC 0080 (Diagnostic Cardiac Catheterization) based on the information provided by hospitals that the codes assigned to this APC do not always require a device for which there is an appropriate HCPCS code. Therefore, we no longer consider this APC to be device dependent and have removed it from the list of device-dependent APCs. In the case of some procedures assigned to other device-dependent APCs, where we determined that no device was required to provide a particular service or where there were no HCPCS codes that described all devices that could be used to furnish the service, we removed the requirement for a device code for the individual procedure code but retained the device requirement for other procedure codes assigned to that device-dependent APC.

In its February 2005 meeting, the APC Panel recommended that we consider calculating the median costs for APCs 0107 (Insertion of Cardioverter Defibrillator) and 0108 (Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads) by bypassing the line-item costs of CPT code 33241 (Subcutaneous removal of single or dual chamber pacing cardioverter-defibrillator pulse generator) and packaging the line item-costs of CPT codes 93640 (Electrophysiological evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement) and 93641 (Electrophysiological evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator) when these codes, separately or in combination, are reported on the same claim with HCPCS codes G0297 (Insertion of single chamber pacing cardioverter defibrillator pulse generator), G0298 (Insertion of dual chamber pacing cardioverter defibrillator pulse generator), G0299 (Insertion or repositioning of electrode lead for single chamber pacing cardioverter defibrillator and insertion of pulse generator) and G0300 (Insertion or repositioning of electrode lead(s) for dual chamber pacing cardioverter defibrillator and insertion of pulse generator), which are assigned to APCs 0107 and 0108. The APC Panel recommended bypassing the line-item costs for CPT code 33241 because members believed that when a pacing cardioverter-defibrillator (ICD) pulse generator removal is performed in the same operative session as the insertion of a new pulse generator described by a procedure code assigned to APC 0107 or 0108, the packaging on the claim is appropriately assigned to the procedure code in APC 0107 or 0108. Moreover, CPT codes 93640 and 93641 may only be correctly coded when the electrophysiologic evaluation of ICD leads is performed at the time of initial implantation or replacement of an ICD

pulse generator and/or leads, with or without testing of the pulse generator. Thus, the APC Panel expected that the costs of the evaluations of the ICD leads (CPT codes 93640 and 93641) could be appropriately packaged with the procedure codes that describe the insertion of ICD generators, which are assigned to APCs 0107 and 0108, or the insertion of ICD leads assigned to APCs 0106 (Insertion/Replacement/Repair of Pacemaker and/or Electrodes), 0108, and 0418 (Insertion of Left Ventricular Pacing Elect). Because APCs 0107 and 0108 have typically had very few single bills on which the medians have been based, and because the APC Panel indicated that it believed that we could use many more claims if we bypassed CPT code 33241 and packaged CPT codes 93640 and 93641, we calculated median costs for APCs 0107 and 0108 using these rules. We excluded claims that did not meet the device edits, and we also excluded token claims.

The effect of packaging CPT codes 93640 and 93641 into claims that both pass the device edits and also contain no token charges for devices are shown in Table 19 below. This affected APCs 0106, 0107, 0108, and 0418. Bypassing the line-item cost of CPT code 33241 could not be done for all claims on which this CPT code was reported because there are clinical circumstances in which the ICD pulse generator is removed and no new device is implanted. Therefore, the APC assignment for CPT code 33241 and the payment for that code need to reflect the packaging associated with the procedure when it is performed alone. Because of this problem with assigning packaging in all the circumstances in which the procedure may be reported, we decided against proposing to bypass CPT code 33241, either in general for all procedures or selectively, when it is reported with the procedures in APCs 0107 and 0108.

However, CPT codes 93640 and 93641 are always performed during an operative procedure for ICD initial implantation or replacement or with implantation, revision or replacement of leads, and, therefore, it would be appropriate to package them into the surgical procedure with which they are performed. Moreover, as a result of the descriptors of the lead evaluation CPT codes, they should never be billed as single procedure claims and packaging them would also resolve the problem of setting their payment rates in part on the basis of claims that reflect erroneous coding. Packaging the costs of the intraoperative electrophysiologic testing of the ICD leads yields many more single bills on which to set median costs and also increases the median costs for APCs 0106, 0107, 0108, and 0418. Therefore, we are proposing to package CPT codes 93640 and 93641 for CY 2007.

We calculated the median cost for device-dependent APCs using two different sets of claims. We first calculated a median cost using all single procedure claims for the procedure codes in those APCs. We also calculated a second median cost using only claims that contain allowed device codes and also for which charges for all device codes were in excess of $1.00 (nontoken charge device claims). We excluded claims for which the charge for a device was less than $1.01, in part, to recognize hospital charging practices due to a recall of cardioverter defibrillator and pacemaker pulse generators in CY 2005 for which the manufacturers provided replacement devices without cost to the beneficiary or hospital. We also found that there are other devices for which the charge was less than $1.01, and we removed those claims also.

As expected, the median costs calculated using all single procedure bills, including both bills that lack appropriate device codes (where there are edits) and bills with token charges for devices, are, in many cases, less than the medians calculated using only claims that contain appropriate device codes and that have no token charges for devices. In some cases the medians are significantly different when claims either without device codes or which have only token device charges are removed. We believe that the claims that reflect the best estimated costs for these APCs, including the costs of the devices, are those claims that contain appropriate devices and which also have no token charges for devices. (See section IV.A.4. below for our discussion of payments when the hospital incurs no cost for the principal device required for the service.)

When we compare the proposed median costs calculated using only CY 2005 claims that contain correct device codes and which do not contain token charges for devices to the unadjusted median costs that were derived from CY 2004 claims data, we find that the medians for only 2 APCs decline (6.3 percent for APC 0061 (Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve) and 2.78 percent for APC 0115 (Cannula/Access Device Procedures)). When we compared the proposed CY 2007 medians to the adjusted medians used to set the payment rates for CY 2006, only 6 APCs would decline more than 10 percent in median cost. This compares favorably to the data for the CY 2006 OPPS final rule with comment period in which 12 APCs declined more than 10 percent when the unadjusted median cost from the data for the CY 2006 OPPS final rule with comment period were compared to the adjusted median cost on which the CY 2005 OPPS payments were based. Some APC cost variation from year to year, whether increasing or decreasing, is to be expected.

Therefore, we are proposing to base the payment rates for CY 2007 for these device-dependent APCs on median costs calculated using claims with appropriate device codes and which have no token charges for devices reported on the claim. We do not believe that adjustment of these median costs is necessary to provide adequate payment for these services, and, therefore, we are not proposing to adjust the median costs for these APCs to moderate any decreases in medians from CY 2006 to CY 2007. We recognize that, notwithstanding the device edits, it may continue to be necessary for purposes of median cost calculations to remove claims that do not contain devices because it is likely that there would be incidental occurrences of interrupted procedures in which a device is not used and does not appear on the claim. (The interrupted procedure modifier nullifies the device edit.) Moreover, there are likely to continue to be incidental occurrences of token charges for devices as a result of devices that are replaced without cost by the manufacturer. However, each of these circumstances could cause the procedure code median cost to underrepresent the cost of the complete procedure, including the device cost, where the hospital purchases the device.

Hence, we believe that use of claims that meet the device edits and which do not contain token charges for devices are the appropriate claims to use to set the median costs for the device-dependent APCs, ensuring that the costs of the principal devices are included in the APC medians. In addition, we believe that, with our proposed changes to the OPPS packaging status of two codes for electrophysiologic evaluation of ICD leads, no special payment policies are needed to establish payment rates that correctly reflect the relative costs of these procedures to other procedures paid under the OPPS.

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Table 18. -- CY 2007 Proposed Median Costs for Device-Dependent APCs

APC	SI	APC Group Title	Hospitals Billing the APC in CY 2005 (Based on CY 2005 Data)	CY 2005 Total Frequency	CY 2005 All Single Bill Frequency	CY 2005 All Single Bill Median	Proposed CY 2007 Nontoken Pass Edit Frequency	Proposed CY 2007 Nontoken Pass Edit Median Cost
0039	S	Level I Implantation of Neurostimulator	192	1692	704	$10,828.96	610	$10,866.68
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	699	11468	2568	$3,309.88	1112	$3,482.71
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	223	2239	429	$5,599.60	205	$5,203.01
0081	T	Non-Coronary Angioplasty or Atherectomy	756	136188	2574	$2,437.57	1950	$2,649.11
0082	T	Coronary Atherectomy	15	195	19	$3,426.83	6	$4,706.61
0083	T	Coronary Angioplasty and Percutaneous Valvuloplasty	213	4046	442	$3,254.89	299	$3,551.16
0085	T	Level II Electrophysiologic Evaluation	515	19083	2109	$2,136.32	1290	$2,143.82
0086	T	Ablate Heart Dysrhythm Focus	311	9622	895	$2,829.20	632	$2,912.10
0087	T	Cardiac Electrophysiologic Recording/Mapping	93	13123	155	$964.13	47	$2,027.77
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	666	4264	1931	$6,736.01	332	$7,531.77
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	313	6540	583	$5,806.75	449	$6,042.93
0104	T	Transcatheter Placement of Intracoronary Stents	198	4607	583	$4,588.58	348	$5,434.23
0106	T	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	325	3819	494	$2,549.70	409	$2,764.49
0107	T	Insertion of Cardioverter-Defibrillator	206	16276	886	$11,215.82	481	$17,245.40
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	262	9075	2950	$22,362.68	2577	$22,887.64

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APC	SI	APC Group Title	Hospitals Billing the APC in CY 2005 (Based on CY 2005 Data)	CY 2005 Total Frequency	CY 2005 All Single Bill Frequency	CY 2005 All Single Bill Median	Proposed CY 2007 Nontoken Pass Edit Frequency	Proposed CY 2007 Nontoken Pass Edit Median Cost
0115	T	Cannula/Access Device Procedures	882	7952	2094	$1,873.02	1276	$1,820.60
0202	T	Level X Female Reproductive Proc	1762	15937	8613	2541.39	3679	2648.26
0222	T	Implantation of Neurological Device	713	6400	2043	$10,864.54	1694	$11,002.44
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	114	848	162	$14,463.01	59	$14,463.32
0227	T	Implantation of Drug Infusion Device	283	3085	535	$9,696.85	260	$11,315.39
0229	T	Transcatherter Placement of Intravascular Shunts	441	48773	1148	$4,015.60	773	$4,081.53
0259	T	Level VI ENT Procedures	152	1168	687	$22,962.48	417	$25,127.88
0315	T	Level II Implantation of Neurostimulator	179	682	535	$14,682.42	453	$14,550.70
0384	T	GI Procedures with Stents	1343	20932	6246	$1,398.50	6155	$1,400.71
0385	S	Level I Prosthetic Urological Procedures	317	810	551	$4,687.67	193	$4,902.56
0386	S	Level II Prosthetic Urological Procedures	844	4580	3197	$8,002.65	1460	$8,383.48
0418	T	Insertion of Left Ventricular Pacing Elect.	113	4824	225	$9,696.51	146	$16,546.34
0425	T	Level II Arthroplasty with Prosthesis	268	1050	412	$6,544.76	369	$6,495.73
0427	T	Level III Tube Changes and Repositioning	680	6604	2778	$684.79	1632	$711.67
0622	T	Level II Vascular Access Procedures	2104	54138	27113	$1,387.19	22001	$1,401.99
0623	T	Level III Vascular Access Procedures	2356	63703	34569	$1,703.94	20221	$1,758.15
0648	T	Breast Reconstruction with Prosthesis	271	1301	271	$2,944.82	229	$3,012.92
0652	T	Insertion of Intraperitoneal and Pleural Catheters	984	5420	3360	$1,805.43	3357	$1,805.17
0653	T	Vascular Reconstruction/Fistula Repair with Device	399	27131	656	$1,942.96	623	$1,914.77
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker	658	25762	1914	$6,053.10	1037	$6,932.30
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	1156	12967	7533	$8,294.96	704	$9,459.63

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APC	SI	APC Group Title	Hospitals Billing the APC in CY 2005 (Based on CY 2005 Data)	CY 2005 Total Frequency	CY 2005 All Single Bill Frequency	CY 2005 All Single Bill Median	Proposed CY 2007 Nontoken Pass Edit Frequency	Proposed CY 2007 Nontoken Pass Edit Median Cost
0656	T	Transcatheter Placement of Intracoronary Drug-Eluting Stents	374	24013	3226	$6,509.27	2469	$6,602.19
0670	S	Level II Intravascular and Intracardiac Ultrasound and Flow Reserve	135	8295	199	$1,578.43	127	$1,836.44
0674	T	Prostate Cryoablation	292	2901	1868	$6,557.73	1495	$6,660.22
0680	S	Insertion of Patient Activated Event Recorders	627	2065	1318	$4,275.01	860	$4,625.52
0681	T	Knee Arthroplasty	59	588	393	$10,436.25	270	$10,689.90

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TABLE 19.—EFFECT OF PACKAGING CPT CODES 93640 AND 93641 ON ALL SINGLE BILLS

APC	SI	APC group title	Post cost total frequency	Proposed CY 2007 single bill frequency 93640/93641 not packaged	Proposed CY 2007 single bill median 93640/93641 not packaged	Proposed CY 2007 single bill frequency 93640/93641 packaged	Proposed CY 2007 single bill median 93640/93641 packaged
0106	T	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	3819	457	$2,459.08	494	$2,549.70
0107	T	Insertion of Cardioverter-Defibrillator.	16276	481	9,669.32	886	11,215.82
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	9075	929	18,030.96	2950	22,362.68
0418	T	Insertion of Left Ventricular Pacing Elect.	4824	142	5,098.03	225	9,696.51

3. Devices Billed in the Absence of an Appropriate Procedure Code

In the course of examining claims data for creation of the payment rates for this proposed rule, we identified circumstances in which hospitals billed a device code but failed to also bill any procedure code with which the device could be used correctly. These errors in billing lead to the costs of the device being packaged with an incorrect procedure code and also cause the hospital to be paid incorrectly for the service furnished if the device was appropriately reported. We discussed the billing of devices with incorrect procedure codes with the APC Panel at its March 2006 meeting, and the APC Panel recommended that we explore the extent to which it would be appropriate to establish edits for HCPCS device codes to ensure that hospitals also bill procedures in which the devices would be used on the same claim.

We examined our CY 2005 claims data and found that incorrect billing occurs more often with some devices than with others. We are taking this opportunity to inform the public that we expect to implement device to procedure code edits for the specified devices and their associated procedures, which we believe must be reported on a claim with the specified device for the claim to be correctly coded and the device costs properly attributed to procedures with which they are used. The devices for which we expect to implement edits are shown below in Table 20 and are posted on the CMS outpatient hospital Web site, along with our initial draft of all the procedures with which they could be appropriately used and thus reported. We believe the establishment of claims edits reflects merely operational and administrative practice. However, as the public may assist in establishing appropriate edits, we, therefore, are asking that comments regarding the specific associations of device codes and procedure codes be provided to the following e-mail address: *OutpatientPPS@cms.hhs.gov*. This is the same e-mail address to which comments on the existing procedure to device edits should be directed.

Comments submitted on this issue to this mail box are not comments on this proposed rule and we will not respond to them in the CY 2007 OPPS final rule.

TABLE 20.—DEVICES WHICH MUST BE BILLED WITH ASSOCIATED PROCEDURE CODES

Device	Description
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1767	Generator, neuro non-recharg.
C1777	Lead, AICD, endo single coil.
C1778	Lead, neurostimulator.

TABLE 20.—DEVICES WHICH MUST BE BILLED WITH ASSOCIATED PROCEDURE CODES—Continued

Device	Description
C1779	Lead, pmkr, transvenous VDD.
C1785	Pmkr, dual, rate-resp.
C1786	Pmkr, single, rate-resp.
C1820	Generator, neuro rechg bat sys.
C1882	AICD, other than sing/dual.
C1895	Lead, AICD, endo dual coil.
C1896	Lead, AICD, non sing/dual.
C1897	Lead, neurostim test kit.
C1898	Lead, pmkr, other than trans.
C1899	Lead, pmkr/AICD combination.
C1900	Lead, coronary venous.
C2619	Pmkr, dual, non rate-resp.
C2620	Pmkr, single, non rate-resp.
C2621	Pmkr, other than sing/dual.

4. Proposed Payment Policy When Devices are Replaced Without Cost or Where Credit for a Replaced Device Is Furnished to the Hospital

As we discuss above in the context of the calculation of median costs for ICDs and pacemakers, in recent years there have been several field actions and recalls with regard to failure of these devices. In many of these cases, the manufacturers have offered replacement devices without cost to the hospital or credit for the device being replaced if the patient required a more expensive device. In some circumstances manufacturers have also offered, through a warranty package, to pay specified amounts for unreimbursed expenses to persons who had replacement devices implanted. In addition, we believe that incidental device failures that are covered by manufacturer warranties occur routinely. While we understand that some device malfunctions may be inevitable as medical technology grows increasingly sophisticated, we believe that early recognition of problems would reduce the number of people with the potential to be adversely affected by these device problems. The medical community needs heightened and early awareness of patterns of device failures, voluntary field actions, and recalls so that they can take appropriate action to care for our beneficiaries. Systematic efforts must be undertaken by all interested and involved parties, including manufacturers, insurers, and the medical community, to ensure that device problems are recognized and addressed as early as possible so that people's health is protected and high quality medical care is provided. We are taking several steps to assist in the early recognition and analysis of patterns of device problems to minimize the potential for harmful device-related effects on the health of Medicare beneficiaries and the public in general.

In recent years, CMS has recognized the importance of data collection as a condition of Medicare coverage for selected services. In 2005, CMS issued a National Coverage Determination (NCD) that expanded coverage of ICDs and required registry participation when the devices were implanted for certain clinical indications. The NCD included this requirement in order to ensure that the care received by Medicare beneficiaries was reasonable and necessary and, therefore, appropriately reimbursed. Presently, the American College of Cardiology—National Cardiovascular Data Registry (ACC—NCDR) collects these data and maintains the registry.

In addition to ensuring appropriate payment of claims, collection, and ongoing analysis of ICD implantation, data can speed public health action in the event of future device recalls. The systematic recording of device manufacturer and model number can enhance patient and provider notification. Analysis of registry data may uncover patterns in complication rates (for example, device malfunction, device-related infection, and early battery depletion) associated with particular devices that signify the need for a more specific investigation. Patterns found in registry data may identify problems earlier than the currently available mechanisms, which do not systematically collect such detailed information surrounding procedures.

We encourage the medical community to work to develop additional registries for implantable devices, so that timely and comprehensive information is available regarding devices, recipients of those devices, and their health status and outcomes. While participation in an ICD registry is required as a condition of coverage for ICD implantation for certain clinical conditions, we believe that the potential benefits of registries extend well beyond their application in Medicare's specific national coverage determinations. As medical technology continues to swiftly advance, data collection regarding the short and long term outcomes of new technologies, and especially concerning implanted devices that may remain in the bodies of patients for their lifetimes, will be essential to the timely recognition of specific problems and patterns of complications. This information will facilitate early interventions to mitigate harm and improve the quality and efficiency of health care services.

Moreover, data from registries may help further the development of high quality, evidence-based clinical practice guidelines for the care of patients who may receive device-intensive procedures. In turn, widespread use of evidence-based guidelines may reduce variation in medical practice, leading to improved personal and public health. Registry information may also contribute to the development of more comprehensive and refined quality metrics that may be used to systematically assess and then improve the safety and quality of health care. Such improvements in the quality of care that result in better personal health will require the sustained commitment of industry, payers, health care providers, and others towards that goal, along with excellent and open communication and rapid system-wide responses in a comprehensive effort to protect and enhance the health of the public. We look forward to further discussions with the public about new strategies to recognize device problems early and how to definitively address them, in order to minimize both the harmful health effects and increased health care costs that may result.

In addition, we believe that the routine identification of Medicare claims where hospitals identify and then appropriately report selected services performed under the OPPS when devices are replaced without cost to the hospital or with full credit to the hospital for the cost of the replaced device, should provide comprehensive information regarding the outpatient hospital experiences of Medicare beneficiaries with certain devices that are being replaced. Because Medicare beneficiaries are common recipients of implanted devices, this claims information may be particularly helpful in identifying patterns of device problems early in their natural history so that appropriate strategies to reduce future problems may be developed.

In addition to our concern for the public health, we also have a fiduciary responsibility to the Medicare trust fund to ensure that Medicare pays only for covered services. Therefore, we are proposing, effective for services furnished on or after January 1, 2007, to reduce the APC payment and beneficiary copayment for selected APCs in cases in which an implanted

device is replaced without cost to the hospital or with full credit for the removed device. Specifically, we are proposing to revise the existing regulations by adding new § 419.45, Payment and copayment reduction for replaced devices. This regulation is intended to cover certain devices for which credit for the replaced device is given or which are replaced as a result of or pursuant to a warranty, field action, voluntary recall, involuntary recall, and certain devices which are provided free of charge. It would provide for a reduction in the APC payment rate when we determine that the device is replaced without cost to the provider or beneficiary or when the provider receives full credit for the cost of a replaced device. The amount of the reduction to the APC payment rate would be calculated in the same manner as the offset amount that would be applied if the implanted device assigned to the APC had pass-through status as defined under § 419.66. The beneficiary's copayment amount would be calculated based on the reduced APC payment rate.

We believe that this is appropriate because in these cases the full cost of the replaced device is not incurred and, therefore, we believe that an adjustment to the APC payment is necessary to remove the cost of the device. We believe that the averaging nature of the calculation of the amount of the adjustment causes it to be appropriately applied to cases of credit for the replaced device, regardless of whether there is a residual cost due to the implantation of a more expensive device.

We also believe that the proposed adjustment is consistent with section 1862(a)(2) of the Act, which excludes from Medicare coverage an item or service for which neither the beneficiary nor anyone on his or her behalf has an obligation to pay. Payment of the full APC payment rate in these cases in which the device was replaced under warranty or in which there was a full credit for the price of the recalled or failed device effectively results in Medicare payment for a noncovered item. Moreover, it results in creation of a beneficiary liability for the copayment associated with the device for which the beneficiary has no liability. Therefore, we are proposing to adjust the APC payment rate in these circumstances under the authority of section 1833(t)(2)(E) of the Act, which permits us to make equitable adjustments to the OPPS payment rates.

We recognize that in many cases, the packaged cost of the device is a relatively modest part of the APC payment for the procedure into which the device cost is packaged. In the case of devices of modest cost, we believe that the averaging nature of payments under the OPPS based on the conversion of charges to costs with CCRs would incorporate any significant savings from a warranty replacement, field action, or recall into the payment rate for the associated procedural APC and that no specific adjustment would be necessary or appropriate. However, in other cases, such as implantation of an ICD, the cost of the device is the majority of the cost of the APC and payment at the full payment rate for the procedural APC would pay the hospital much in excess of its incurred cost of the service.

As we discuss above, we are proposing to set the APC payment rates for device-dependent APCs for the CY 2007 OPPS using only claims that contain appropriate devices to ensure that we make appropriate full payment when the hospital initially incurs the full cost of the device. Beginning in CY 2005, we required that device codes be billed for devices used and specifically required that hospitals bill certain device codes for some services. We are using the CY 2005 claims to set the payment rates for the CY 2007 OPPS. Currently, where the device is furnished without cost to the hospital, we have authorized hospitals to charge less than $1.01, although Medicare's longstanding policy has been that, in these cases, providers may not charge for the device furnished to them without cost. (See the Medicare Internet Only Manual, Medicare Benefit Policy Manual, Publication 100–02 Chapter 16, section 40.4.)

We authorized this charge because the CMS device edits require that the hospital must report an appropriate device if they bill for certain codes that cannot be performed without a device or the claim will be returned. Moreover, the Fiscal Intermediary Standard System will not accept the claim unless there is a charge for each HCPCS code billed. In addition, we were seeking a means of identifying these recall cases in the data. Therefore, by authorizing hospitals to charge less than $1.01 for the device we enabled the claim to be paid and also provided a mechanism for identifying devices for which the hospital incurred no expense.

Where we set the payment rates for these device-dependent APCs using only claims that contain the full costs of devices when they are purchased by hospitals and exclude claims for which there is no appropriate device code or a charge for the device of less than $1.01, the proposed APC payments into which the full costs of the devices have been packaged would result in excessive program payments and beneficiary copayments for the services being furnished if the devices were provided without cost to hospitals. To avoid excessive payments in these circumstances, as noted previously we are proposing to adjust the APC payment rates when implanted devices have been replaced without cost to the hospital or beneficiary or where full credit for such a device has been given because the replacement device is of greater cost than the originally implanted device.

We are proposing that the adjustment would be limited to the APCs listed in Table 21, but only when the purpose of the procedure is to replace a device that is reported by a HCPCS code in Table 22 which was furnished without cost or at full credit by the manufacturer. We are proposing that the following three criteria must each be met for an APC to be subject to the adjustment. We selected the APCs in Table 21 on the basis of these three criteria.

The first criterion is that all procedures assigned to the selected APCs must require implantable devices that would be reported if device replacement procedures were performed. Therefore, the device being replaced must be necessary for the service to be furnished and without the devices, the services assigned to the APCs could not be performed. For services, and, therefore, their assigned APCs, where a device is not needed or where it may or may not be needed to perform a procedure, we do not believe that reducing the payment for the APCs would be appropriate because the charges for the devices are unlikely to be a significant factor in establishing the rates for the APCs.

The second criterion is that the required devices must be surgically inserted or implanted devices that remain in the patient's body after the conclusion of the procedures, at least temporarily. We believe this is necessary to establish that the replacement device is a direct replacement for the device being removed. In cases of failures of devices that are surgically inserted or implanted but do not remain in the patient's body after the conclusion of procedures, we believe that it is highly likely that the replacement device is not specifically used to care for the patient on whom the original defective device was used and that, where a defective device of this type is used, there is no savings to the hospital. For example, if a vascular catheter fails during a procedure, we believe that the physician will probably

use another similar catheter to finish the procedure. In these cases the hospital would correctly charge for the catheter that was used, and there would be no savings to the hospital from that procedure. The hospital would likely charge for both the defective device and the device used to complete the procedure because both catheters were used to provide the full service. We believe that if a replacement catheter is furnished to the hospital under warranty from the manufacturer, it would be used at a much later date on a different patient, it would most likely be charged to that patient account, and it would be unlikely to be specifically identified as being furnished without cost to the hospital. In these cases, we expect that any cost savings from the replacement devices such as these (for example, catheters) that are furnished without cost would be incorporated into the median costs for the procedures in the normal course of the data process through application of the CCRs generated from the cost reports.

The third criterion is that the offset percent for the APC (that is, the median cost of the APC without device costs divided by the median cost of the APC with devices) must be significant. For this purpose, we are defining a significant offset percent as exceeding 40 percent. We believe that this percent is appropriate because our studies have shown that approximately 60 percent of the cost of OPPS services is wage-related, and that approximately 40 percent of the cost of OPPS services is not wage related. This is why we wage adjust 60 percent of the APC payment rates for all APCs, including APCs for which a greater percentage of the APC payment is for the cost of a device.

We believe that once the device share of an APC exceeds the 40 percent we attribute to costs other than wage costs (for example, device costs, capital costs, plant costs, and supplies other than devices), the device cost is a significant part of the APC cost. Therefore, where the device costs in an APC exceed 40 percent, which is the average of all types of nonwage-related costs across all APCs, we are proposing to define the device costs as ''significant'' for purposes of this proposed policy.

We recognize that it may be appropriate to define ''significant'' for this purpose at a different percentage of the APC cost because there are costs other than device costs (for example, capital costs and other supply costs) in the 40 percent of service costs to which the wage adjustment does not apply. We would reassess for future years whether it is appropriate to define ''significant'' for this purpose at a level other than 40 percent.

For purposes of making the proposed adjustment, we would adapt the methodology that we have employed to establish an offset for the device costs incorporated into APCs in cases where a pass-through device is also being billed. We currently calculate the offset amount by first calculating a median including the device costs and then calculating a median excluding device costs using single bills that contain devices. We then divide the ''without device'' median by the ''with device'' median and subtract the percent from 100 to acquire the percent of cost attributable to devices in the APC. We apply this percent to the payment rate of the APC to determine the offset amount. For example, this is the methodology we used to calculate the offset amount for APC 0222 when current pass-through device C1820 (Generator, neuro rechg bat sys) is billed on the same claim. We believe that it is appropriate to apply this same methodology in circumstances when we need to remove the cost of the device from the APC payment, not because the device is being paid under pass-through but because the hospital is either not incurring the cost for the replaced device or has been given full credit for the replaced device. In both cases, the intent is to remove the cost of the device from the APC payment rate.

Using this methodology, we calculated the proposed offset amounts in Table 21 by first calculating an APC median cost including device costs and then calculating a median cost excluding device costs, using only single bills that meet our device edits and do not have token charges for devices. We then divided the ''without device'' median cost by the ''with device'' median cost and subtracted the percent from 100 to acquire the percent of cost attributable to devices in the APC. We next applied this percent to the payment rate for the APC to determine the offset amount.

The following is an example of the payment reduction in the case of replacement of an ICD under warranty. Where the cardioverter defibrillator pulse generator described by HCPCS code C1721 (AICD, dual chamber) is replaced under warranty during a procedure described by HCPCS code G0298 (Insertion of dual chamber pacing cardioverter defibrillator pulse generator), the hospital would report HCPCS code G0298 with a specified modifier and would also report HCPCS code C1721 with a token charge for the device. Assuming the hospital had a wage index of 1, the payment rate for APC 0107 after adjustment would be $1862.27. That is, the adjusted payment rate would equal the unadjusted payment rate for APC 0107 ($17,185.34) less the warranty reduction percentage in Table 21 of 89.13 percent ($15,317.29). Because the adjustment amount is set for the APC, the same adjustment amount would be removed if devices reported under HCPCS code C1722 or C1882 were reported with HCPCS code G0297. This is identical to the amount of adjustment that would apply to the payment for a pass-through device if there were, hypothetically, a new ICD to which we had given pass-through status (no ICD currently has pass-through status).

We are proposing to both adjust the APC payment to remove payment for the device furnished without cost to the hospital or beneficiary and also to decrease the beneficiary copayment in proportion to the reduced APC payment so that the beneficiary would, in many but not all cases, share in the cost savings attributable to the provision of the device without cost by the manufacturer. We are proposing that when a device is replaced without cost to the hospital under warranty or recall or a credit is provided for the cost of a failed or recalled device (unlike cases of offset for a pass-through device), the beneficiary's copayment would be calculated based on the reduced APC payment rate, maintaining the same percentage copayment as applies to the unadjusted APC payment if the inpatient deductible is not exceeded. We believe that it is appropriate to reduce the beneficiary copayment in these cases because the device is being furnished or credited by the manufacturer without obligation on the part of the beneficiary. We note, however, that in the case of some high cost APCs, making the payment adjustment in a recall or warranty situation may not result in reduction of the copayment because the copayment, although based on the reduced payment rate, may continue to exceed the inpatient deductible and, therefore, would continue to be set at the inpatient deductible.

In contrast, in the case of pass-through devices, the beneficiary is liable for the copayment on the full APC amount (which, in the case of high cost APCs, is limited to the Medicare inpatient deductible) but pays no copayment for the incremental cost of the pass-through device. This is appropriate in the case of payment for pass-through devices because the hospital incurs costs for both the service and the device, and Medicare pays for both the service through the full APC

payment and for the incremental cost of the pass-through device above the costs of associated devices already reflected in the APC payment at charges reduced to cost by a CCR. The pass-through payment amount is reduced only to prevent the program from making duplicate payment for a portion of the device, once as part of the APC payment and once through the pass-through payment.

We are proposing to implement the adjustment through the use of an appropriate modifier specific to a device replacement without cost or crediting of the cost of a device by the manufacturer. Hospitals would be required to report the modifier appended to a specific procedure on claims for services when two conditions are met. The first condition is that the procedure is assigned to one of the APCs in Table 21. We have discussed above the criteria that we employed for selecting the APCs in Table 21. The second condition is that the device for which the manufacturer furnished a replacement device (or provided credit for the device being replaced) is one of the devices included in Table 22. We are restricting the devices to which the adjustment would apply to those included in Table 22 in order to ensure that the adjustment is not triggered by the replacement of an inexpensive device whose cost does not constitute a significant proportion of the total payment rate for an APC.

The presence of the modifier would trigger the adjustment in payment for the APCs in Table 21. While we recognize that this creates a reporting burden for hospitals, we believe the reporting requirement is unavoidable. Only hospitals can report whether the circumstances for reduced payment as described above are met and, therefore, we see no option other than to have hospitals report this information to us. We recognize that the current FB modifier (''Item furnished without cost to provider, supplier or practitioner'') may not be appropriate in cases in which the replacement device is a more expensive device than the device being removed and may need to be changed to expand its use for all potential APC payment adjustment scenarios.

Our proposed policy would accomplish three important goals. First and foremost, it would advise us of the extent to which devices are being replaced due to device failures so that, if patterns are identified, we can explore them to see if there are systemic problems with certain devices. The reporting of a specific modifier with certain procedure codes would allow us to examine patterns of delivery of specific hospital services when implanted devices are replaced without cost or with full credit for the cost of a device by the manufacturer, in comparison with publicly available information about problematic devices. Analysis of outpatient hospital claims would serve as an additional source of information to the medical community about patterns of device failures, voluntary field actions, and recalls, contributing to improved awareness and understanding of problems.

Secondly, it would ensure equitable adjustment to the payments for surgical procedures to replace problematic devices by providing payments to hospitals only for the nondevice related procedural costs when a device is replaced without cost to the hospital for the device or with full credit for the removed device. Thirdly, it would also identify those claims that contain reduced device charges due to the full credit provided by the manufacturer for a replaced device so that in the future we can assess the impact of these claims on median costs for the services into which the device costs are packaged.

This proposed policy would be effective for services furnished on or after January 1, 2007. We believe that this proposed policy is necessary to enable us to secure claims data that may be used to identify trends in device problems that lead to device replacements. It is also necessary to fulfill our fiduciary responsibility to the Medicare program by not providing payments for items that are excluded from coverage under Medicare law because neither the beneficiary nor any party on his or her behalf has an obligation to pay.

TABLE 21.—PROPOSED ADJUSTMENT TO APCS IN CASES OF REPLACEMENT OF OR FULL CREDIT FOR FAILED OR RECALLED DEVICE

APC	SI	APC group title	CY 2007 proposed offset percent
0039	S	Level I Implantation of Neurostimulator	78.51%
0040	S	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve	54.66%
0061	S	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excludin	60.59%
0089	T	Insertion/Replacement of Permanent Pacemaker and Electrodes	77.14%
0090	T	Insertion/Replacement of Pacemaker Pulse Generator	74.56%
0106	T	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	41.04%
0107	T	Insertion of Cardioverter-Defibrillator	89.13%
0108	T	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	89.15%
0222	T	Implantation of Neurological Device	78.10%
0225	S	Implantation of Neurostimulator Electrodes, Cranial Nerve	80.62%
0226	T	Implantation of Drug Infusion Reservoir	62.21%
0227	T	Implantation of Drug Infusion Device	81.50%
0229	T	Transcatherter Placement of Intravascular Shunts	42.32%
0259	T	Level VI ENT Procedures	84.03%
0315	T	Level II Implantation of Neurostimulator	83.52%
0385	S	Level I Prosthetic Urological Procedures	46.88%
0386	S	Level II Prosthetic Urological Procedures	61.32%
0418	T	Insertion of Left Ventricular Pacing Elect	86.11%
0654	T	Insertion/Replacement of a permanent dual chamber pacemaker	76.73%
0655	T	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker	76.89%
0680	S	Insertion of Patient Activated Event Recorders	77.03%
0681	T	Knee Arthroplasty	73.26%

TABLE 22.—DEVICES FOR WHICH THE PROPOSED MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR AT FULL CREDIT FOR A REPLACED DEVICE

Device	Description
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1764	Event recorder, cardiac.
C1767	Generator, neurostim, imp.
C1771	Rep dev, urinary, w/sling.
C1772	Infusion pump, programmable.
C1776	Joint device (implantable).
C1777	Lead, AICD, endo single coil.
C1778	Lead, neurostimulator.
C1779	Lead, pmkr, transvenous VDD.
C1785	Pmkr, dual, rate-resp.
C1786	Pmkr, single, rate-resp.
C1813	Prosthesis, penile, inflatab.
C1815	Pros, urinary sph, imp.
C1820	Generator, neuro rechg bat sys.
C1882	AICD, other than sing/dual.
C1891	Infusion pump, non-prog, perm.
C1895	Lead, AICD, endo dual coil.
C1896	Lead, AICD, non sing/dual.
C1897	Lead, neurostim, test kit.
C1898	Lead, pmkr, other than trans.
C1899	Lead, pmkr/AICD combination.
C1900	Lead coronary venous.
C2619	Pmkr, dual, non rate-resp.
C2620	Pmkr, single, non rate-resp.
C2621	Pmkr, other than sing/dual.
C2622	Prosthesis, penile, non-inf.
C2626	Infusion pump, non-prog, temp.
C2631	Rep dev, urinary, w/o sling.
L8614	Cochlear device/system.

B. Proposed Pass-Through Payments for Devices

(If you choose to comment on issues in this section, please include the caption ''Pass-Through Devices'' at the beginning of your comment.)

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

a. Background

Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, a category of devices be eligible for transitional pass-through payments for at least 2, but not more than 3, years. This period begins with the first date on which a transitional pass-through payment is made for any medical device that is described by the category. The device category codes became effective April 1, 2001, under the provisions of the BIPA. Prior to pass-through device categories, Medicare payments for pass-through devices under the OPPS were made on a brand-specific basis. All of the initial 97 category codes that were established as of April 1, 2001, have expired; 95 categories expired after CY 2002, and 2 categories expired after CY 2003. In addition, nine new categories have expired since their creation. We currently have no category codes for pass-through devices that will expire January 1, 2007. We created one new category effective January 1, 2006, for C1820 (Generator, neurostimulator (implantable), with rechargeable battery and charging system), which we are proposing to continue to pay under the pass-through provision in CY 2007 under the OPPS. This category was created after we published modifications to our criteria in the CY 2006 OPPS final rule with comment period on November 10, 2005 (70 FR 68628 through 68631) allowing CMS to refine previous pass-through category descriptions that would have prevented us from making pass-through payments for a new technology that otherwise met our criteria. These modifications amended the original criteria and process for creating additional device categories for pass-through payment that we published on November 2, 2001 (66 FR 55850 through 55857). Under our established policy, we base the expiration dates for the category codes on the date on which a category was first eligible for pass-through payment.

In the November 1, 2002 OPPS final rule, we established a policy for payment of devices included in pass-through categories that are due to expire (67 FR 66763). For CY 2003 through CY 2006, we packaged the costs of the devices no longer eligible for pass-through payments into the costs of the procedures with which the devices were billed in the claims data used to set the payment rates for those years. Brachytherapy sources, which are now separately paid in accordance with section 1833(t)(2)(H) of the Act, are an exception to this established policy (with the exception of brachytherapy sources for prostate brachytherapy, which were packaged in the CY 2003 OPPS only).

b. Proposed Policy for CY 2007

As we stated earlier, currently we have one effective device category for pass-through payment, C1820, which we created for pass-through payment effective January 1, 2006. We are proposing to continue to make payment under the pass-through provisions for category C1820 for CY 2007. We are proposing that this category would expire from pass-through payment after December 31, 2007. This would provide the category transitional pass-through payment status for a 2-year period, in accordance with the statutory requirement that no category be paid as a pass-through device for less than 2 years, nor more than 3 years.

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

a. Background

In the November 30, 2001 OPPS final rule, we explained the methodology we used to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of the associated devices that are eligible for pass-through payments (66 FR 59904). Beginning with the implementation of the CY 2002 OPPS quarterly update (April 1, 2002), we deducted from the pass-through payments for the identified devices an amount that reflected the portion of the APC payment amount that we determined was associated with the cost of the device, as required by section 1833(t)(6)(D)(ii) of the Act. In the November 1, 2002 interim final rule with comment period, we published the applicable offset amounts for CY 2003 (67 FR 66801).

For the CY 2002 and CY 2003 OPPS updates, to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment, we used claims data from the period used for recalibration of the APC rates. That is, for CY 2002 OPPS updating, we used CY 2000 claims data, and for CY 2003 OPPS updating, we used CY 2001 claims data. For CY 2002, we used median cost claims data based on specific revenue centers used for device-related costs because C-code cost data were not available until CY 2003. For CY 2003, we calculated a median cost for every APC without packaging the costs of associated C-codes for device categories that were billed with the APC. We then calculated a median cost for every APC with the costs of the associated device category C-codes that were billed with the APC packaged into the median. Comparing the median APC cost without device packaging to the median APC cost, including device packaging, enabled us to determine the percentage of the median APC cost that is attributable to the associated pass-through devices. By applying those percentages to the APC payment rates, we determined the applicable amount to be deducted from the pass-through payment, the ''offset'' amount. We created an offset list comprised of any APC for which the device cost was at least 1 percent of the APC's cost.

The offset list that we published for CY 2002 through CY 2004 was a list of offset amounts associated with those APCs with identified offset amounts developed using the methodology described above. As a rule, we do not

know in advance which procedures residing in certain APCs may be billed with new device categories. Therefore, an offset amount is applied only when a new device category is billed with a HCPCS procedure code that is assigned to an APC appearing on the offset list.

For CY 2004, we modified our policy for applying offsets to device pass-through payments. Specifically, we indicated that we would apply an offset to a new device category only when we could determine that an APC contains costs associated with the device. We continued our existing methodology for determining the offset amount, described earlier. We were able to use this methodology to establish the device offset amounts for CY 2004 because providers reported device codes (C-codes) on the CY 2002 claims used for the CY 2004 OPPS update. For the CY 2005 update to the OPPS, our data consisted of CY 2003 claims that did not contain device codes and, therefore, for CY 2005, we utilized the device percentages as developed for CY 2004. In the CY 2004 OPPS update, we reviewed the device categories eligible for continuing pass-through payment in CY 2004 to determine whether the costs associated with the device categories are packaged into the existing APCs. Based on our review of the data for the device categories existing in CY 2004, we determined that there were no close or identifiable costs associated with the devices relating to the respective APCs that are normally billed with them. Therefore, for those device categories, we set the offset amount to $0 for CY 2004. We continued this policy of setting the offset amount to $0 for the device categories that continued to receive pass-through payment in CY 2005.

For the CY 2006 OPPS update, CY 2004 hospital claims were available for analysis. Hospitals billed device C-codes in CY 2004 on a voluntary basis. We reviewed our CY 2004 data and found that the numbers of claims for services in many of the APCs for which we calculated device percentages using CY 2004 data were quite small. We also found that many of these APCs already had relatively few single claims available for median calculations compared with the total bill frequencies because of our inability to use many multiple bills in establishing median costs for all APCs. In addition, we found that our claims demonstrated that relatively few hospitals specifically coded for devices utilized in CY 2004. Thus, we were not confident that CY 2004 claims reporting C-codes represented the typical costs of all hospitals providing the services. Therefore, we did not use CY 2004 claims with device coding to calculate CY 2006 device offset amounts. In addition, we did not use the CY 2005 methodology, for which we utilized the device percentages as developed for CY 2004. Two years had passed since we developed the device offsets for CY 2004, and the device offsets originally calculated from CY 2002 hospitals' claims data may either have overestimated or underestimated the contributions of device costs to total procedural costs in the outpatient hospital environment of CY 2004. In addition, a number of the APCs on the CY 2004 and CY 2005 device offset percentage lists were either no longer in existence or were so significantly reconfigured that the past device offsets likely did not apply.

For CY 2006, we reviewed the single new device category established thus far, C1820, to determine whether device costs associated with the new category are packaged into the existing APC structure. Under our established policy, if we determine that the device costs associated with the new category are closely identifiable to device costs packaged into existing APCs, we set the offset amount for the new category to an amount greater than $0. Our review of the service indicated that the median costs for the applicable APC 0222 (Implantation of Neurological Device) contained costs for neurostimulators similar to the costs of the new device category C1820. Therefore, we determined that a device offset would be appropriate. We announced an offset amount for that category in Program Transmittal No. 804, dated January 3, 2006.

For CY 2006, we are using available partial year CY 2005 hospital claims data to calculate device percentages and potential offsets for CY 2006 applications for new device categories. Effective January 1, 2005, we require hospitals to report device C-codes and their costs when hospitals bill for services that utilize devices described by the existing C-codes. In addition, during CY 2005, we implemented device edits for many services that require devices and for which appropriate device C-codes exist. Therefore, we expected that the number of claims that include device codes and their respective costs to be much more robust and representative for CY 2005 than for CY 2004. We believe that use of the most current claims data to establish offset amounts when they are needed to ensure appropriate payment is consistent with our stated policy; therefore, we are proposing to continue to do so for the CY 2007 OPPS. Specifically, if we create a new device category for payment in CY 2007, to calculate potential offsets we are proposing to examine the most current available claims data, including device costs, to determine whether device costs associated with the new category are already packaged into the existing APC structure, as indicated earlier. If we conclude that some related device costs are packaged into existing APCs, we are proposing to use the methodology described earlier and first used for the CY 2003 OPPS to determine an appropriate device offset percentage for those APCs with which the new category would be reported.

We did not publish a list of APCs with device percentages as a transitional policy for CY 2006 because of the previously discussed limitations of the CY 2004 OPPS data with respect to device costs associated with procedures. We stated in the CY 2006 final rule with comment period (70 FR 68628) that we expected to reexamine our previous methodology for calculating the device percentages and offset amounts for the CY 2007 OPPS update, which would be based on CY 2005 hospital claims data where device C-code reporting is required.

b. Proposed Policy for CY 2007

For CY 2007, we are proposing to continue to review each new device category on a case-by-case basis as we have done in CY 2004, CY 2005, and CY 2006, to determine whether device costs associated with the new category are packaged into the existing APC structure. If we determine that, for any new device category, no device costs associated with the new category are packaged into existing APCs, we are proposing to continue our current policy of setting the offset amount for the new category to $0 for CY 2007. There is currently one new device category that would continue for pass-through payment in CY 2007. This category, described by HCPCS code C1820, currently has an offset amount of $8,647.81, which is applied to APC 0222. We are proposing to update this offset for CY 2007 based on the full year of claims data for CY 2005, the claims data year for our CY 2007 rate update. We are proposing an offset amount for C1820 of 78.1 percent of the proposed CY 2007 payment rate for APC 0222 based on the CY 2005 data used to calculate the proposed payment amount in this proposed rule. (See Addendum A of this proposed rule for a listing of the proposed CY 2007 APC payment rates.)

We are proposing to continue our existing policy to establish new

categories in any quarter when we determine that the criteria for granting pass-through status for a device category are met. If we create a new device category and determine that our data contain a sufficient number of claims with identifiable costs associated with the new category of devices in any APC, we are proposing to adjust the APC payment if the offset amount is greater than $0. If we determine that a device offset greater than $0 is appropriate for any new category that we create, we are proposing to announce the offset amount in the program transmittal that announces the new category.

In summary, for CY 2007, we are proposing to use CY 2005 hospital claims data to calculate device percentages and potential offsets for CY 2007 applications for new device categories. We are proposing to publish, through program transmittals, any new or updated offsets that we calculate for CY 2007, corresponding to newly created categories or existing categories, respectively.

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

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

(If you choose to comment on issues in this section, please include the caption ''Pass-Through Drugs'' at the beginning of your comment.)

1. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain drugs and biological agents. As originally enacted by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act (BBRA) of 1999 (Pub. L. 106–113), this provision requires the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act (Pub. L. 107–186); current drugs and biological agents and brachytherapy sources used for the treatment of cancer; and current radiopharmaceutical drugs and biological products. For those drugs and biological agents referred to as ''current,'' the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act BIPA of 2000 (Pub. L. 106–554), on December 21, 2000).

Transitional pass-through payments are also required for certain ''new'' drugs and biological agents that were not being paid for as a hospital outpatient department service as of December 31, 1996, and whose cost is ''not insignificant'' in relation to the OPPS payments for the procedures or services associated with the new drug or biological. Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years. In Addenda A and B of this proposed rule, proposed CY 2007 pass-through drugs and biological agents are identified by status indicator ''G.''

The process to apply for transitional pass-through payment for eligible drugs and biological agents can be found on our CMS Web site: *http://www.cms.hhs.gov.* If we revise the application instructions in any way, we will post the revisions on our Web site and submit the changes to the Office of Management and Budget (OMB) for approval, as required under the Paperwork Reduction Act (PRA). Notification of new drugs and biologicals application processes is generally posted on the OPPS Web site at: *http://www.cms.hhs.gov/providers/hopps.*

2. Expiration in CY 2006 of Pass-Through Status for Drugs and Biologicals

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less than 2 years and no longer than 3 years. The 12 drugs and biologicals listed in Table 23, whose pass-through status will expire on December 31, 2006, meet that criterion. For all drugs and biologicals with pass-through status expiring on December 31, 2006, that are currently assigned temporary C-codes, if there is a permanent HCPCS code available for CY 2007 that describes the product, then we are proposing to delete the C-code and use the permanent HCPCS code for purposes of OPPS billing and payment for the product in CY 2007. Based on our review of the existing permanent HCPCS codes available at the time of this proposed rule, we have determined that HCPCS code J7344 (Nonmetabolic active tissue) appropriately describes the product reported under HCPCS code C9221 in the CY 2006 OPPS; therefore, we propose to delete C9221 and pay for this product using J7344 in CY 2007. The coding changes for the other products will depend on what the final HCPCS codes are for CY 2007, which will be included in the CY 2007 OPPS final rule. We specifically request comments on this proposed policy for CY 2007.

TABLE 23.—PROPOSED LIST OF DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES DECEMBER 31, 2006

HCPCS	APC	Short descriptor
C9220 ..	9220	Sodium hyaluronate.
C9221 ..	9221	Graftjacket Reg Matrix.
C9222 ..	9222	Graftjacket Sft Tis.
J0128 ..	9216	Abarelix injection.
J0878 ..	9124	Daptomycin injection.
J2357 ..	9300	Omalizumab injection.
J2783 ..	0738	Rasburicase.
J2794 ..	9125	Risperidone, long acting.
J7518 ..	9219	Mycophenolic acid.
J9035 ..	9214	Bevacizumab injection.
J9055 ..	9215	Cetuximab injection.
J9305 ..	9213	Pemetrexed injection.

3. Drugs and Biologicals With Proposed Pass-Through Status in CY 2007

We are proposing to continue pass-through status in CY 2007 for nine drugs and biologicals. These items, which are listed in Table 24 below, were given pass-through status as of April 1, 2006. The APCs and HCPCS codes for drugs and biologicals that we are proposing to continue with pass-through status in CY 2007 are assigned status indicator ''G'' in Addenda A and B of this proposed rule.

Section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs (assuming that no pro rata reduction in pass-through payment is necessary) as the amount determined under section 1842(o) of the Act. We note that this section 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 1847A of the Act, as added by section 303(c) of Pub. L. 108–173, establishes the use of the average sales price (ASP) methodology as the basis for payment of drugs and biologicals described in section 1842(o)(1)(C) of the Act and furnished on or after January 1, 2005. This payment methodology is set forth in § 419.64 of the regulations. Section 1847B of the Act, as added by section 303(d) of Pub. L. 108–173, establishes the payment methodology for drugs and biologicals under the competitive acquisition program. The competitive acquisition program was implemented as of July 1, 2006. The list of drugs and biologicals covered under this program can be found on *http://www.cms.hhs.gov/CompetitiveAcquisforBios,* along with

their payment rates and information on the program's methodology.

Section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs as the amount determined under section 1842(o) of the Act, or 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. For CY 2007, under the OPPS we are proposing payment for drugs and biologicals with pass-through status that will also be covered under the competitive acquisition program to be based on the competitive acquisition program methodology. Similar to the payment policy established for pass-through drugs and biologicals in CY 2006, we are proposing to pay under the OPPS for all other drugs and biologicals with pass-through status in CY 2007 consistent with the provisions of section 1842(o) of the Act, as amended by section 621 of Pub. L. 108–173, at a rate that is equivalent to the payment these drugs and biologicals would receive in the physician office setting.

Table 24 lists the drugs and biologicals for which we are proposing that pass-through status continue in CY 2007. Of these nine drugs and biologicals, only HCPCS codes J2503 (Pegaptanib sodium injection) and J9264 (Paclitaxel injection) are covered under the competitive acquisition program at the time of the development of this proposed rule. Therefore, in CY 2007, we are proposing to set payment for HCPCS codes J2503 and J9264 at the amounts determined under the competitive acquisition program, which will be a rate slightly different than the rate determined under the ASP methodology. Payment for all other drugs and biologicals would be equivalent to the payment these drugs and biologicals would receive in the physician office setting in CY 2007, where payment will be determined by the methodology described in § 419.904 and generally be equal to ASP+6 percent. In accordance with the ASP methodology, in the absence of ASP data, we are continuing the policy we implemented during CYs 2005 and 2006 of using the wholesale acquisition cost (WAC) for the product to establish the initial payment rate. We note, however, that if the WAC is also unavailable, then we would make payment at 95 percent of the product's most recent AWP. We adopted this interim payment methodology in order to be consistent with how we pay for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes, as discussed in the CY 2006 OPPS final rule with comment period (70 FR 68669). We further note that with respect to items for which we currently do not have ASP data, once their ASP data become available in later quarter submissions, their payment rates under OPPS will be adjusted so that the rates are based on the ASP methodology and set to ASP+6 percent.

Currently, there are no radiopharmaceuticals that would have pass-through status in CY 2007. In the event that a new radiopharmaceutical agent receives pass-through status in CY 2007, we propose to base its payment on the WAC for the product as ASP data for radiopharmaceuticals are not available. We note, however, that if the WAC is also unavailable, then we would calculate payment for the radiopharmaceutical at 95 percent of its most recent AWP. We are proposing to adopt this interim payment methodology in order to be consistent with how we pay for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes, as discussed in the CY 2006 OPPS final rule with comment period (70 FR 68669).

Section 1833(t)(6)(D)(i) of the Act also sets the amount of additional payment for pass-through eligible drugs and biologicals (the pass-through payment amount). The pass-through payment amount is the difference between the amount authorized under section 1842(o) of the Act (or under section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract), and the portion of the otherwise applicable fee schedule amount (that is, the APC payment rate) that the Secretary determines is associated with the drug or biological.

We discuss in section V.B.3.b. of the preamble that we are proposing to make separate payment in CY 2007 for new drugs and biologicals with a HCPCS code, consistent with the provisions of section 1842(o) of the Act at a rate that is equivalent to the payment they would receive in a physician office setting (or under section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract), whether or not we have received a pass-through application for the item. Accordingly, in CY 2007 the pass-through payment amount would equal zero for those new drugs and biologicals that we determine have pass-through status. That is, when we subtract the amount to be paid for pass-through drugs and biologicals under section 1842(o) of the Act (or section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract), from the portion of the otherwise applicable fee schedule amount or the APC payment rate associated with the drug or biological that would be the amount paid for drugs and biologicals under section 1842(o) of the Act (or section 1847B of the Act, if the drug or biological is covered under a competitive acquisition contract), the resulting difference is equal to zero.

We are proposing to use payment rates based on the ASP data from the fourth quarter of CY 2005 for budget neutrality estimates, impact analyses, and to complete Addenda A and B of this proposed rule because these are the most recent data available to us at this time. These payment rates are also the basis for drug payments in the physician office setting effective April 1, 2006. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices, we are proposing to make any appropriate adjustments to the amounts shown in Addenda A and B of this proposed rule when we publish our CY 2007 OPPS final rule and also on a quarterly basis on our Web site during CY 2007 if later quarter ASP submissions (or more recent WACs or AWPs) indicate that adjustments to the payment rates for these pass-through drugs and biologicals are necessary. The payment rate for a radiopharmaceutical with pass-through status would also be adjusted accordingly. We also are proposing to make appropriate adjustments to the payment rates for these drugs and biologicals in the event that they become covered under the competitive acquisition program in the future. For drugs and biologicals that are currently covered under the competitive acquisition program, we are proposing to use the payment rates calculated under this program that are in effect as of July 1, 2006. We are proposing to update these payment rates if the rates change in the future.

Table 24 lists the drugs and biologicals for which we are proposing that pass-through status continue in CY 2007. We assigned pass-through status to these drugs and biologicals as of April 1, 2006. We also have included in Addenda A and B of this proposed rule, the proposed CY 2007 APC payment rates for all pass-through drugs and biologicals, based on ASP data from the fourth quarter of CY 2005 (or if applicable, payment rates calculated under the competitive acquisition program) as described above.

TABLE 24.—PROPOSED LIST OF DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2007

HCPCS	APC	Short descriptor
C9225 ..	9225	Fluocinolone acetonide.
C9227 ..	9227	Injection, micafungin sodium.
C9228 ..	9228	Injection, tigecycline.
J2278 ..	1694	Ziconotide injection.
J2503 ..	1697	Pegaptanib sodium injection.
J8501 ..	0868	Oral aprepitant.
J9027 ..	1710	Clofarabine injection.
J9264 ..	1712	Paclitaxel injection.
Q4079	9126	Natalizumab injection.

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

(If you choose to comment on issues in this section, please include the caption ''OPPS: Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals'' at the beginning of your comment.)

1. Background

Under the CY 2006 OPPS, we currently pay for drugs, biologicals, and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment within the payment for the associated service or separate payment (individual APCs). We explained in the April 7, 2000 OPPS final rule with comment period (65 FR 18450) that we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any packaged items and supplies whose costs are recognized and paid within the national OPPS payment rate for the associated procedure or service. (Program Memorandum Transmittal A–01–133, issued on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.)

Packaging costs into a single aggregate payment for a service, procedure, or episode of care is a fundamental principle that distinguishes a prospective payment system from a fee schedule. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. Notwithstanding our commitment to package as many costs as possible, we are aware that packaging payments for certain drugs, biologicals, and radiopharmaceuticals, especially those that are particularly expensive or rarely used, might result in insufficient payments to hospitals, which could adversely affect beneficiary access to medically necessary services.

Section 1833(t)(16)(B) of the Act, as added by section 621(a)(2) of Pub. L. 108–173, requires that the threshold for establishing separate APCs for drugs and biologicals be set at $50 per administration for CYs 2005 and 2006. However, this requirement for establishing the packaging threshold will expire at the end of CY 2006. For CY 2006, we finalized our policy to continue paying separately for drugs, biologicals, and radiopharmaceuticals whose per day cost exceeds $50 and packaging the costs of drugs, biologicals, and radiopharmaceuticals whose per day cost is less than $50 into the procedures with which they are billed. For CY 2006, we also continued an exception policy to our packaging rule for one particular class of drugs, the oral and injectable 5HT3 forms of anti-emetic treatments (70 FR 68635 through 68638).

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

During the March 2006 meeting of the APC Panel, the Panel recommended that CMS maintain the $50 packaging threshold or if the threshold is reevaluated, that CMS provide the Panel with data that indicate the costs of packaged drugs that are incorporated into drug administration payment rates.

As indicated above, in accordance with section 1833(t)(16)(B) of the Act, the threshold for establishing separate APCs for drugs and biologicals was set to $50 per administration during CYs 2005 and 2006. Because this packaging threshold will expire at the end of CY 2006, we evaluated four options for packaging levels so that we could determine what the appropriate packaging threshold proposal for drugs, biologicals, and radiopharmaceuticals would be for the CY 2007 OPPS update.

One of the packaging options we considered for the CY 2007 OPPS update was to pay separately for all drugs, biologicals, and radiopharmaceuticals with a HCPCS code. This would be a straightforward policy that would speed the creation of procedural APC medians. However, this policy would be inconsistent with OPPS packaging principles, reduce hospitals' incentives for economy and efficiency, and increase hospitals' administrative burden related to separate billing for more drugs, biologicals, and radiopharmaceuticals.

The second option we considered for CY 2007 was to increase the packaging threshold to a level much higher than the current $50 threshold. This option would result in the packaging of more drugs, biologicals, and radiopharmaceuticals and would be more consistent with OPPS packaging principles. This option would also provide greater administrative simplicity for hospitals. However, implementation of this option might result, in some cases, in the drug administration payments being less than the cost of the packaged drugs. Relatively expensive drugs, biologicals, and radiopharmaceuticals could also be packaged under this option.

The third packaging threshold option we evaluated was to maintain the packaging threshold at $50. We believe that this is a reasonable policy option that would provide stability to the payment system, as the packaging threshold has been set at $50 since CY 2004. This policy option would also be consistent with the APC Panel recommendation to maintain the packaging threshold at $50 in CY 2007; however, this policy would not take into account price inflation in determining the drug packaging threshold since the $50 threshold was initially established.

Consequently, the fourth option we considered and are proposing for CY 2007 and subsequent years is to update the packaging threshold for inflation using an inflation adjustment factor based on the Producer Price Index (PPI) for prescription preparations. In order to update the packaging threshold for CY 2007 under this proposal, we used the four quarter moving average PPI levels for prescription preparations to trend the $50 threshold forward from the third quarter of CY 2005 (when the Pub. L. 108–173-mandated threshold became effective) to the third quarter of CY 2007. We are proposing that for each year beginning with CY 2007, we would adjust the packaging threshold by the PPI for prescription drugs, and the adjusted dollar amount would be rounded to the nearest $5 increment in order to determine the new threshold. The adjusted amount for CY 2007 was calculated to be $55.99, which we are rounding to $55. Therefore, for CY 2007, we are proposing to pay separately for drugs, biologicals, and radiopharmaceuticals whose per day cost exceeds $55 and packaging the costs of drugs, biologicals, and radiopharmaceuticals whose per day cost is less than or equal to $55 into the procedures with which they are billed.

This proposed policy is consistent with the principle employed in many health care payment policy areas (and many other areas of government policy) of acknowledging the real costs by using an inflation adjustment instead of static dollar values. We believe that our proposed policy is consistent with the APC Panel's recommendation because we would be maintaining the $50 threshold in terms of its real value during the calendar year in which it would be in effect. Also, in the absence of a mechanism to update the threshold, we believe that current relatively inexpensive drugs would begin to receive separate payment over time. The PPI for prescription preparations reflects price changes at the wholesale or manufacturer stage. Because OPPS payment rates for drugs and biologicals are generally based on average sales price (ASP) data that are reported by their manufacturers, we believe that the PPI for prescription preparations would be an appropriate price index to use to update the packaging threshold for CY 2007 and beyond.

For CY 2007, we are also proposing to continue our policy of exempting the oral and injectable 5HT3 anti-emetic products from our packaging rule (Table 25), thereby making separate payment for all of the 5HT3 anti-emetic products. As stated in the CY 2005 OPPS final rule with comment period (69 FR 65779 through 65780), chemotherapy is very difficult for many patients to tolerate, as the side effects are often debilitating. In order for Medicare beneficiaries to achieve the maximum therapeutic benefit from chemotherapy and other therapies with side effects of nausea and vomiting, anti-emetic use is often an integral part of the treatment regimen. We believe that we should continue to ensure that Medicare payment rules do not impede a beneficiary's access to the particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician. We solicit comments on these packaging proposals.

TABLE 25.—PROPOSED ANTI-EMETICS TO EXEMPT FROM PROPOSED $55 PACKAGING REQUIREMENT

HCPCS code	Short description
J1260	Dolasetron mesylate.
J1626	Granisetron HCl injection.
J2405	Ondansetron HCl injection.
J2469	Palonosetron HCl.
Q0166	Granisetron HCl 1 mg oral.
Q0179	Ondansetron HCl 8 mg oral.
Q0180	Dolasetron mesylate oral.

To determine their CY 2007 proposed packaging status, we calculated the per day cost of all drugs, biologicals, and radiopharmaceuticals that had a HCPCS code in CY 2005 and were paid (via packaged or separate payment) under the OPPS using claims data from January 1, 2005, to December 31, 2005. In CY 2005, multisource drugs and radiopharmaceuticals had two HCPCS codes that distinguished the innovator multisource (brand) drug or radiopharmaceutical from the noninnovator multisource (generic) drug or radiopharmaceutical. We aggregated claims for both the brand and generic HCPCS codes in our packaging analysis of these multisource products. In order to calculate the per day cost for drugs, biologicals, and radiopharmaceuticals to determine their packaging status in CY 2007, we are proposing to use the methodology that was described in detail in the CY 2006 OPPS proposed rule (70 FR 42723 through 42724) and finalized in the CY 2006 OPPS final rule with comment period (70 FR 68636 through 68638). However, in our calculation of per day costs for this proposed rule for the CY 2007 OPPS update, we used the payment rate for each drug and biological at its ASP+5 percent which was based on manufacturer-submitted ASP data from the fourth quarter of CY 2005. The ASP data from this period were also the basis for determining payments for drugs and biologicals in the physician office setting, effective April 1, 2006. The rationale for using ASP+5 percent as the payment for drugs and biologicals is described in section V.B.3.a.2. of this preamble. For items that did not have an ASP-based payment rate, we used their mean unit cost derived from the CY 2005 hospital claims data to determine their per day cost. We packaged the items with per day cost less than or equal to $55 and made items with per day cost greater than $55 separately payable. We are requesting comments on the methodology we are proposing to use to determine the per day cost of drugs, biologicals, and radiopharmaceuticals under the CY 2007 OPPS update.

Our policy during previous cycles of the OPPS has been to use updated data for the final rules. For the CY 2007 OPPS final rule, we are proposing to use the ASP data from the first quarter of CY 2006, which would be the basis for calculating payment rates for drugs and biologicals in the physician office setting using the ASP methodology effective July 1, 2006, along with updated hospital claims data from CY 2005 to determine the final per day costs of drugs, biologicals, and radiopharmaceuticals and their packaging status in CY 2007. Subsequently, payment rates for CY 2007 separately payable drugs and biologicals will be updated to reflect applicable ASP-based rates effective in the physician office setting for services effective January 1, 2007.

Because, for the CY 2007 OPPS final rule, we are proposing to use ASP data from the first quarter of CY 2006, which would be the basis for calculating payment rates for drugs and biologicals in the physician office setting using the ASP methodology, effective July 1, 2006, along with updated hospital claims data from CY 2005 to determine the final per day costs of drugs, biologicals, and radiopharmaceuticals, the packaging status of these items using the updated data may be different from their packaging status determined based on the data we are using for this proposed rule. Under such circumstances, we are proposing to apply the following policies to these drugs, biologicals, and radiopharmaceuticals whose relationship to the $55 threshold changes based on the final updated data:

- Drugs, biologicals, and radiopharmaceuticals that were paid separately in CY 2006 (which are proposed for separate payment in CY 2007), and then have per day costs less than $55 based on the updated ASPs and hospital claims data that would be used for the CY 2007 final rule with comment period, would continue to receive separate payment in CY 2007.
- Drugs, biologicals, and radiopharmaceuticals that were packaged in CY 2006, (which are proposed for separate payment in CY 2007), and then have per day costs less than $55 based on the updated ASPs and hospital claims data that would be used for the CY 2007 final rule with comment period, would remain packaged in CY 2007.
- Drugs, biologicals, and radiopharmaceuticals for which we propose packaged payment in CY 2007 but then have per day costs greater than $55 based on the updated ASPs and hospital claims data that would be used for the CY 2007 final rule with comment period, would receive separate payment in CY 2007.

We are requesting specific comments on these proposed policies for CY 2007.

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

a. Proposed Payment for Specified Covered Outpatient Drugs

(1) Background

Section 1833(t)(14) of the Act, as added by section 621(a)(1) of Public Law 108–173, requires special classification of certain separately paid radiopharmaceuticals, drugs, and biologicals and mandates specific payments for these items. Under section 1833(t)(14)(B)(i) of the Act, a ''specified covered outpatient drug'' is a covered outpatient drug, as defined in section 1927(k)(2) of the Act, for which a separate APC exists and that either is a radiopharmaceutical agent or is a drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

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

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

Section 1833(t)(14)(A)(iii) of the Act, as added by section 621(a)(1) of Pub. L. 108 173, requires that payment for specified covered outpatient drugs in CY 2006 and subsequent years be equal to the average acquisition cost for the drug for that year as determined by the Secretary subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the Government Accountability Office (GAO) in CYs 2004 and 2005. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act as calculated and adjusted by the Secretary as necessary.

For CY 2006, we adopted a policy of paying for the acquisition and overhead costs of separately paid drugs and biologicals at a combined rate of ASP+6 percent. To calculate the ASP+6 percent payment rate, we evaluated the three data sources that were available to us for setting the CY 2006 payment rates for drugs and biologicals. As described in the CY 2006 OPPS final rule with comment period (70 FR 68639 through 68644), these data sources were the GAO reported average purchase prices for 55 specified covered outpatient drug categories for the period July 1, 2003 to June 30, 2004 collected via a survey of 1,400 acute care Medicare-certified hospitals; ASP data; and mean costs derived from CY 2004 hospital claims data used in developing the CY 2006 final rule with comment period. For the CY 2006 final rule with comment period, we used ASP data from the second quarter of CY 2005, which were used to set payment rates for drugs and biologicals in the physician office setting effective October 1, 2005. We also used updated claims data, reflecting all of the hospital claims data from CY 2004 and updated CCRs.

In our data analysis for the CY 2006 OPPS final rule with comment period, we compared the payment rates for drugs and biologicals using data from all three sources described above. We estimated aggregate expenditures for all drugs and biologicals (excluding radiopharmaceuticals) that would be separately payable in CY 2006 and for the 55 drugs and biologicals reported by the GAO using mean costs from the claims data, the GAO mean purchase prices, and the ASP-based payment amounts (ASP+6 percent in most cases), and then calculated the equivalent average ASP-based payment rate under each of the three payment methodologies. The results based on updated ASP and claims data were published in Table 24 of the CY 2006 OPPS final rule with comment period. For a full discussion of our reasons for using these data, refer to section V.B.3.a. of the CY 2006 OPPS final rule with comment period (70 FR 68639 through 68644).

As noted in the CY 2006 OPPS final rule with comment period, findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their pharmacy handling costs as well as their acquisition costs. Therefore, we believe the MedPAC survey indicated 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.

(2) Proposed Payment Policy for CY 2007

The provision in section 1833(t)(14)(A)(iii) of the Act, as described above, continues to be applicable to determining payments for specified covered outpatient drugs for CY 2007. Similar to CY 2006, this provision requires that in CY 2007 payment for specified covered outpatient drugs be equal to the average acquisition cost for the drug for that year as determined by the Secretary subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the Government Accountability Office (GAO) in CYs 2004 and 2005. If hospital acquisition cost data are not available, the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847A, or section 1847B of the Act as calculated and adjusted by the Secretary as necessary. Additionally, section 1833(t)(14)(E)(ii) authorizes the Secretary to adjust APC weights for specified covered outpatient drugs to take into account the MedPAC report relating to overhead and related expenses, such as pharmacy services and handling costs.

For the CY 2007 proposed rule, we evaluated two data sources that we have available to us for setting the CY 2007 payment rates for drugs and biologicals. The first source of drug pricing information that we have is the ASP data from the fourth quarter of CY 2005, which were used to set payment rates for drugs and biologicals in the physician office setting effective April 1, 2006. We have ASP-based prices for approximately 500 drugs and biologicals (including contrast agents) payable under the OPPS; however, we currently do not have any ASP data on radiopharmaceuticals. Payments for most of the drugs and biologicals paid in the physician office setting are based on ASP+6 percent, and payments for items with no reported ASP are based on wholesale acquisition cost (WAC).

The second source of cost data that we have for drugs, biologicals, and radiopharmaceuticals are the mean and median costs derived from the CY 2005 hospital claims data. As section 1833(t)(14)(A)(iii) of the Act clearly specifies that payment for specified covered outpatient drugs in CY 2007 be equal to the ''average'' acquisition cost for the drug, we limited our analysis to the mean costs of drugs determined using the hospital claims data, instead of using median costs.

In our data analysis, we compared the payment rates for drugs and biologicals using data from both sources described above. We estimated aggregate expenditures for all drugs and biologicals (excluding radiopharmaceuticals) that would be separately payable in CY 2007 using mean costs from the hospital claims data and the ASP-based payment amounts (ASP+6 percent in most cases), and calculated the equivalent average ASP-based payment rate under both payment methodologies.

The results of our data analysis indicate that using mean unit cost to set the payment rates for the drugs and biologicals that would be separately payable in CY 2007 would be equivalent to basing their payment rates, on average, at ASP+5 percent. As noted in the CY 2006 proposed and final rules, findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their pharmacy handling costs as well as their acquisition costs. Therefore, the mean costs calculated using charges from hospital claims data converted to costs are representative of hospital acquisition costs for these products, as well as their related pharmacy overhead costs. Our calculations indicate that using mean unit costs to set the payment rates for all separately payable drugs and biologicals would be equivalent to basing their payment rates on the ASP+5 percent, on average. Because pharmacy overhead costs are already built into the charges for drugs, biologicals, and radiopharmaceuticals, our current data therefore indicate that payment for drugs and biologicals and pharmacy overhead at a combined ASP+5 percent rate would serve as the best proxy for the combined acquisition and overhead costs of each of these products. Therefore, for CY 2007, we are proposing a policy of paying for the acquisition and overhead costs of separately paid drugs and biologicals at a combined rate of ASP+5 percent.

In its final report on the hospital acquisition cost survey of specified covered outpatient drugs titled ''Medicare Hospital Pharmaceuticals: Survey Shows Price Variation and Highlights Data Collection Lessons and Outpatient Rate-setting Challenges for CMS'', the GAO recommended that Secretary validate, on an occasional basis, manufacturers' reported drug ASPs as a measure of hospitals' acquisition costs using a survey of hospitals or other method that CMS determines to be similarly accurate and efficient. As we indicated in our written comments to the GAO on its draft report, we will continue to consider the best approach for setting payment rates for drugs and biologicals in light of this recommendation. We also indicated that we will continue to analyze the adequacy of ASP-based pricing in light of our hospital claims data, which for this CY 2007 OPPS proposed rule indicates that ASP+5 percent would be the best available proxy for hospitals' average acquisition and handling costs of drugs and biologicals in CY 2007.

We note that ASP data are unavailable for some drugs and biologicals. For these few drugs and biologicals, we are proposing to use the mean costs from the CY 2005 hospital claims data to determine their packaging status for ratesetting. Until we receive ASP data for these items, payment will be based on their mean cost calculated from CY 2005 hospital claims data. The payment rates for separately payable drugs and biologicals shown in Addenda A and B to this proposed rule represent payments for their acquisition and overhead costs.

Our proposal uses payment rates based on ASP data from the fourth quarter of 2005 because these are the most recent numbers available to us at this time. To be consistent with the ASP data that would be used to determine payments for these drugs and biologicals when furnished in physician offices, we propose to make any appropriate adjustments to the amounts shown in Addenda A and B to this proposed rule for those items on a quarterly basis as more recent ASP data become available and post the payment rate changes on our Web site during each quarter of CY 2007. We note that we would determine the packaging status of each drug or biological only once during the year during the update process; however, for the separately payable drugs and biologicals, we would update their ASP-based payment rates on a quarterly basis.

During the March 2006 meeting of the APC Panel, the Panel recommended that CMS examine pharmacy overhead costs issues and work with appropriate associations to study how to measure pharmacy overhead costs. The Panel also recommended that CMS solicit feedback on how pharmacy overhead costs should be reimbursed in the future.

In response to the APC Panel recommendations, we will continue to work on issues related to pharmacy overhead costs and request comments on other proposals that we can consider when establishing a future pharmacy overhead cost methodology. In addition, we note that we routinely accept requests from interested organizations to discuss their views about OPPS payment policy issues. We will consider the input of any individual or organization to the extent allowed by Federal law, including the Administrative Procedure Act (APA) and the Federal Advisory Committee Act (FACA). We establish the OPPS rates through regulations. We are required to consider the timely comments of interested organizations, establish the payment policies for the forthcoming year, and respond to the timely comments of all public commenters in the final rule in which we establish the payments for the forthcoming year.

We are specifically requesting public comments on our proposal to pay for acquisition and overhead costs of drugs and biologicals under the OPPS at ASP+5 percent and the adequacy of the payment rates to account for actual acquisition and overhead costs incurred by hospitals for these items.

In its October 31, 2005 letter of comment on proposed 2006 SCOD rates titled ''Comments on Proposed 2006 SCOD Rates,'' the GAO recommended that to better approximate hospitals' acquisition costs of SCODs the Secretary reconsider the level of proposed payment rates for drug SCODs, in relation to survey data on average purchase price, the role of rebates in determining acquisition costs, and the desirability of setting payment rates for SCODs at average acquisition costs. In the CY 2006 OPPS proposed rule (70 FR 42726), we noted that the comparison between the GAO purchase price data and the ASP data indicated that the GAO data on average were equivalent to ASP+3 percent. However, we also indicated that using mean unit cost from the CY 2004 hospital claims data to set the payment rates for the drugs and biologicals that would be separately payable in CY 2006 would be equivalent to basing their payment rates, on average, at ASP+8 percent. Therefore, we had proposed to establish payment for drugs and biologicals and their overhead costs at a combined rate of ASP+8 percent, where ASP+6 percent represented the acquisition cost of these items and 2 percent of ASP was for their overhead costs. For the CY 2006 OPPS final rule with comment period, where more recent ASP data, updated CCRs, and updated CY 2004 hospital claims data were available, we found that the comparison between the GAO purchase price data and the ASP data indicated that the GAO data on average were equivalent to ASP+4 percent, and using mean unit cost from hospital claims to set the payment rates for the drugs and

biologicals that would be separately payable in CY 2006 would be equivalent to basing their payment rates, on average, at ASP+6 percent. Because pharmacy overhead costs are already built into the charges for drugs, biologicals, and radiopharmaceuticals, we noted in the CY 2006 OPPS final rule with comment period that our claims data indicated that payment for drugs and biologicals and their pharmacy overhead at a combined ASP+6 percent rate served as the best proxy for the combined acquisition and overhead costs of each of these products. For the CY 2007 proposed rule, as indicated earlier in the preamble, we compared the CY 2005 hospital claims data with more recent ASP data and determined that using mean unit cost to set payment rates for separately payable drugs and biologicals in CY 2007 would be equivalent to basing their payment rates, on average, at ASP+5 percent. This is the policy we are proposing for CY 2007, and we believe that this payment level would serve as the best proxy for the combined acquisition and overhead costs of separately payable drugs and biologicals in CY 2007.

In the CY 2006 OPPS final rule with comment period (70 FR 68661), we indicated that we will be paying for blood clotting factors at ASP+6 percent during CY 2006 under the OPPS and providing payment for the furnishing fee that is also a part of the payment for blood clotting factors furnished in physician offices under Medicare Part B. This furnishing fee will be updated each calendar year based on the consumer price index, and we will update the amount appropriately each year under the OPPS based upon the final amount noted in the Medicare Physician Fee Schedule final rule. In CY 2006, the furnishing fee is $0.146 per unit. For the CY 2007 OPPS, we are proposing to make payment for blood clotting factors at ASP+5 percent along with continuing payment for the furnishing fee using the updated amount for CY 2007. The proposed CY 2007 regulations establishing the ASP methodology and the furnishing fee for blood clotting factors under Medicare Part B can be found in the CY 2007 Medicare Physician Fee Schedule proposed rule. The updated furnishing fee amount for CY 2007 under the OPPS will be announced in the CY 2007 OPPS final rule.

(3) CY 2007 Proposed Payment Policy for Radiopharmaceuticals

Section 303(h) of Pub. L. 108–173 exempted radiopharmaceuticals from ASP pricing in the physician office setting where the fewer numbers (relative to the hospital outpatient setting) of radiopharmaceuticals are priced locally by Medicare contractors. Consequently, we do not have ASP data for radiopharmaceuticals. However, the law also requires us to make payments for specified covered outpatient drugs, including radiopharmaceuticals, equal to the average acquisition cost for the drug as determined by the Secretary and subject to any adjustment for overhead costs. We expect hospitals' different purchasing and preparation and handling practices for radiopharmaceuticals to be reflected in their charges. Therefore, for CY 2006, we calculated per day costs of radiopharmaceuticals using mean unit costs from the CY 2004 hospital claims data to determine the items' packaging status similar to the drugs and biologicals with no ASP data. For CY 2006, we implemented a 1-year temporary policy to pay for separately payable radiopharmaceuticals based on the hospital's charge for each radiopharmaceutical adjusted to cost. We clearly stated in our CY 2006 OPPS final rule with comment period that we did not intend to maintain the CY 2006 methodology permanently (70 FR 68656) and that we would actively seek other methodologies for setting payments for radiopharmaceuticals in CY 2007.

During the March 2006 meeting of the APC Panel, the Panel recommended that CMS work with stakeholders to continue to develop a methodology to pay for radiopharmaceuticals. We note that we routinely accept requests from interested organizations to discuss their views about OPPS payment policy issues. We will consider the input of any individual or organization to the extent allowed by Federal law, including the Administrative Procedure Act (APA) and the Federal Advisory Committee Act (FACA). We establish OPPS rates through regulations. We are required to consider the timely comments of interested organizations, establish the payment policies for the forthcoming year, and respond to the timely comments of all public commenters in the final rule in which we establish the payments for the forthcoming year. We have considered comments and information from interested organizations in developing these policy options for CY 2007.

Over this past year, despite reviews of the literature and numerous discussions with interested individuals and organizations from the radiopharmaceutical industry, we have received no specific suggestions from hospitals or industry regarding alternative prospective payment methodologies for radiopharmaceuticals that could be used in place of our CY 2006 cost-based payment methodology. However, in its final report on the hospital acquisition cost survey of specified covered outpatient drugs, titled '' Medicare Hospital Pharmaceuticals: Survey Shows Price Variations and Highlights Data Collection Lesson and Outpatient Rate-setting Challenges for CMS,'' the GAO acknowledged that the distinctive nature of radiopharmaceuticals as compared with other drugs poses special challenges for collecting and interpreting hospital cost data. They discussed the challenges of balancing accuracy and efficiency in obtaining price data on radiopharmaceutical specified covered outpatient drugs. They concluded that the best option available to CMS, in terms of accuracy and efficiency, is for the Secretary to collect and use ready-to-use unit-dose prices paid by hospitals when available as the data source for setting and updating Medicare payment rates for radiopharmaceutical specified covered outpatient drugs. As we indicated in our written comments to the GAO on its draft report, we remain uncertain about whether a survey to collect unit-dose acquisition costs would be conducted as a survey of hospitals or manufacturers. We are also concerned about the level of expense and administrative burden that would be placed on the party reporting such information, based on the GAO's experience in surveying hospitals regarding radiopharmaceutical acquisition costs. The survey approach could lead to a very inefficient methodology for establishing payment rates. We also note that in conducting a survey to obtain ready-to-use unit-dose prices for radiopharmaceuticals, we would be able to collect this information for only a small number of radiopharmaceuticals that are purchased in unit-dose forms by hospitals; however, we believe that it is important to apply a consistent payment methodology to determine payments for all separately payable radiopharmaceuticals. Even though we are not proposing to adopt the GAO's recommendation for CY 2007, we will continue to explore this recommendation for future updates of the OPPS.

In developing the payment policy proposal for separately payable radiopharmaceuticals for the CY 2007 proposed rule, we considered several additional policy options. The first option we considered proposing was to package additional

radiopharmaceuticals, either through packaging payments for all radiopharmaceuticals with payments for the services with which they are billed or increasing the packaging threshold for radiopharmaceuticals from a cost of $55 per day to a higher amount. In contrast to other separately payable drugs where the administration of many drugs is reported with only a few drug administration HCPCS codes, only a small number of specific radiopharmaceuticals may be appropriately provided in the performance of each particular nuclear medicine procedure. Because the provision of nuclear medicine procedures always requires one or more radiopharmaceuticals, packaging more radiopharmaceuticals effectively results in some increases in the costs of the associated nuclear medicine procedures to reflect the greater packaging of the radiopharmaceuticals. The specific increased procedural costs observed are dependent upon the volumes and costs of various radiopharmaceuticals used in the procedures and thus reflect an average cost across clinical scenarios where providers may choose among several radiopharmaceuticals for the procedures. A policy to package additional radiopharmaceuticals would be very consistent with OPPS packaging principles and payment policies which generally provide appropriate payment for the average service and would provide greater administrative simplicity for hospitals. Because we believe that radiopharmaceutical handling costs are included in hospitals charges for the radiopharmaceuticals themselves, payments for the nuclear medicine procedures would include payments for the handling costs of the radiopharmaceuticals used under this option.

In examining our claims data for CY 2005, we noted that significant numbers of claims for nuclear medicine procedures included no HCPCS codes for radiopharmaceuticals. While it is possible that hospitals used packaged radiopharmaceuticals in some studies and therefore chose not to report them separately, it is also possible that some hospitals may have included charges for the required radiopharmaceuticals in their charges for the nuclear medicine procedures themselves. Packaging additional radiopharmaceuticals would be consistent with the charging practices of some hospitals that already may not be separately reporting radiopharmaceuticals, even when those radiopharmaceuticals would receive separate payment under the OPPS. Were we to package additional radiopharmaceuticals under the OPPS, consistent with our packaging policies for implantable devices, we might need to establish edits to ensure that radiopharmaceutical charges were always included on claims for nuclear medicine procedures, as has been suggested to us by interested organizations.

However, under a policy of increased packaging of radiopharmaceuticals, payments for certain nuclear medicine procedures could potentially be less than the costs of some of the packaged radiopharmaceuticals and relatively expensive and high volume radiopharmaceuticals could become packaged. In addition, our payment policy could discourage selection of the most clinically appropriate radiopharmaceutical for a particular nuclear medicine procedure, especially if that radiopharmaceutical were expensive and not commonly used so that its costs were not fully reflected in the payment for the nuclear medicine procedure. In addition, the statutory definition of a ''specified covered outpatient drug'' for OPPS purposes that includes radiopharmaceutical agents appears more consistent with the treatment of radiopharmaceuticals like other drugs under the OPPS, at least when this is feasible. We solicit public comment on the merits of establishing a higher packaging threshold for radiopharmaceuticals, given their unique characteristics.

The second option that we considered proposing was to continue the temporary CY 2006 methodology of paying for separately payable radiopharmaceuticals at charges reduced to cost, where payment would be determined using each hospital's overall CCR, and establishing our radiopharmaceutical packaging threshold at $55, as we are proposing for other drugs under the CY 2007 OPPS. This policy would provide stability to the payment methodology for radiopharmaceuticals from CY 2006 to CY 2007. As we indicated for CY 2007, this payment methodology provides an acceptable proxy for the average acquisition of the radiopharmaceutical along with its handling cost.

However, as also indicated previously, we stated in the CY 2006 OPPS final rule with comment period that this payment policy was intended to be only a temporary policy, and that we would consider alternative methodologies to base radiopharmaceutical payments on for the CY 2007 OPPS update. We generally do not make payments under the OPPS for items and services at cost, particularly if we do not expect the costs of services to vary substantially and unpredictably over time and if we have hospital claims data available. Paying for radiopharmaceuticals at cost provides hospitals with no incentive to supply radiopharmaceuticals in the most efficient manner. In its comments on the CY 2006 OPPS proposed rule, the GAO expressed concern that this methodology would be likely to result in payments that exceed hospitals' acquisition costs for certain radiopharmaceuticals. Estimates of our CY 2006 payments for radiopharmaceuticals reveal variation from the 25th to 75th payment percentile of 2 to 9 fold, depending on the specific radiopharmaceutical. We do not believe that the radiopharmaceutical acquisition and handling costs for different hospitals to provide most radiopharmaceuticals should vary that greatly. In addition, using hospitals' overall CCRs to determine payments likely results in an overstatement of radiopharmaceutical costs, which are likely reported in several cost centers such as diagnostic radiology that have lower CCRs than hospitals' overall CCRs.

The third option that we considered and are proposing for CY 2007 is to establish prospective payment rates for separately payable radiopharmaceuticals using mean costs derived from the CY 2005 claims data, where the costs are determined using our standard methodology of applying hospital-specific departmental CCRs to radiopharmaceutical charges, defaulting to hospital-specific overall CCRs only if appropriate departmental CCRs are unavailable. This proposal establishes our packaging threshold for radiopharmaceuticals at $55, as for other drugs under the CY 2007 OPPS. We believe this option provides us with the most consistent, accurate, and efficient methodology for prospectively establishing payment rates for separately payable radiopharmaceuticals. This is our preferred payment proposal for radiopharmaceuticals because this methodology is consistent with how payment rates for other services are determined under the OPPS and provides for prospective payments that serve as appropriate proxies for the average acquisition costs of the radiopharmaceuticals along with their handling costs. The MedPAC has indicated that hospitals currently include the charge for radiopharmaceutical handling in their charge for the radiopharmaceutical. In addition, this approach provides an average payment to hospitals, consistent

with the statutory requirement that we pay the average acquisition cost, in comparison with our CY 2006 cost-based policy which paid each hospital differently for each claim based on the claim's charges and the hospital's overall CCR.

We believe that this methodology would likely pay more accurately for radiopharmaceuticals, and provide incentives for their efficient acquisition and preparation. Also, as discussed earlier, MedPAC indicated that hospitals include charges for handling costs in their charge for radiopharmaceuticals; therefore, mean costs based on our claims data would represent both the acquisition and overhead costs of the separately payable radiopharmaceuticals. We believe that this payment policy could also be an appropriate long-term radiopharmaceutical payment policy that would allow us to consistently establish prospective OPPS payment rates for the acquisition and overhead costs of separately payable radiopharmaceuticals. Because we will be paying separately for radiopharmaceuticals with mean costs per day greater than $55, without additional radiopharmaceutical packaging for CY 2007, we see no reason to establish edits for the presence of radiopharmaceutical codes on claims for nuclear medicine procedures as, in many cases, payments for the procedures do not include payments for the radiopharmaceuticals used.

Under each of the payment options for radiopharmaceuticals, we considered that beginning with CY 2007 and going forward we would update the packaging threshold for inflation using an inflation adjustment factor based on the Producer Price Index (PPI) for prescription preparations. As discussed elsewhere in the preamble, the adjusted amount for CY 2007 was determined to be $55.

In its October 31, 2005 letter of comment on proposed 2006 SCOD rates titled ''Comments on Proposed 2006 SCOD Rates'', the GAO recommended that to better approximate hospitals' acquisition costs of SCODs that the Secretary reconsider the decision to base payment rates for radiopharmaceutical SCODs exclusively on estimated costs in light of the availability of data on actual prices paid for key radiopharmaceuticals. As we did not have ASPs for radiopharmaceuticals that best represent market prices, in the CY 2006 OPPS final rule with comment period, we finalized a temporary 1-year policy for CY 2006 to pay for radiopharmaceuticals that were separately payable in CY 2006 based on the hospital's charge for each radiopharmaceutical agent adjusted to cost. We noted that MedPAC has indicated that hospitals currently include the charge for pharmacy overhead costs in their charge for the radiopharmaceutical. Therefore, we believed that paying for these items on the basis of charges converted to cost would be the best available proxy for the average acquisition cost of the radiopharmaceutical along with its handling cost in CY 2006. We did not use the GAO hospital purchase prices as the basis for setting payments because when we examined differences between the CY 2005 payment rates for these nine radiopharmaceuticals and their GAO mean purchase prices, we found that the GAO purchase prices were substantially lower for several of these agents. We indicated that our intent was to maintain consistency, whenever possible, between the payment rates for these agents from CY 2005 to CY 2006. For CY 2007, however, we considered several payment options for radiopharmaceuticals that we discussed above and are proposing to establish prospective payment rates for separately payable radiopharmaceuticals using mean costs derived from the CY 2005 claims data.

We note that the National HCPCS Panel changed the codes and the descriptors of many of the radiopharmaceutical products effective January 1, 2006, in some cases moving from prior code descriptors based upon units of radioactivity to new descriptors based on study doses. The hospital claims data we used for our analysis are based on radiopharmaceutical HCPCS codes that were in effect during CY 2005. Because there were significant changes in HCPCS code descriptors for several radiopharmaceuticals from CY 2005 to CY 2006, implementation of the proposed payment methodology for radiopharmaceuticals requires us to crosswalk the cost data for these radiopharmaceuticals that are in terms of the CY 2005 codes to the updated CY 2006 codes that we expect to be in effect during CY 2007. The mean cost data per unit of many CY 2005 codes can be directly crosswalked to the new CY 2006 codes because the products and units included in the code descriptors are essentially the same. However, there are several CY 2005 codes with descriptors specifying units of radioactivity that were changed to per study dose units in CY 2006. For these radiopharmaceuticals, we are proposing to calculate their per day costs based on the CY 2005 codes and use those per day costs as proxies for the per study dose costs of the CY 2006 codes. We believe that patients would generally receive one study dose of these radiopharmaceuticals each day, and our CY 2005 claims data show that they were most commonly billed with specific nuclear medicine procedures that normally include a single radiopharmaceutical dose on a given day. Therefore, the per day costs of these radiopharmaceuticals calculated based on claims reporting the CY 2005 codes should be an appropriate basis for determining the payment rates for the CY 2006 HCPCS codes.

Out of the 39 radiopharmaceutical HCPCS codes that we are proposing to pay separately for in CY 2007, we are able to directly crosswalk the CY 2005 cost data to 31 of these codes. The descriptors for the remaining eight codes changed from per unit of radioactivity in CY 2005 to new descriptors based on per study doses in CY 2006. Therefore, we are proposing to use the per day costs based on the CY 2005 claims data as proxies for the per study dose costs for this subset of radiopharmaceutical HCPCS codes to be reported in CY 2007.

There are three cases where two CY 2005 HCPCS codes were mapped to one new CY 2006 code that will be reported in CY 2007. These three CY 2006 HCPCS codes are A9550, A9553, and A9559. Because of the complicated nature of crosswalking the cost data for two predecessor HCPCS codes with different units in their descriptors to each of these new HCPCS codes, we are proposing to crosswalk the cost data only from the predecessor HCPCS codes with the most claims volume in CY 2005 to each of these three HCPCS codes to be reported for CY 2007.

Table 26 below lists all of the CY 2007 separately payable radiopharmaceuticals and the predecessor HCPCS codes whose claims data were used to set the CY 2007 proposed payment rates and notes the crosswalk methodology used for the proposed rates.

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Table 26.-- Proposed Payment Rates and Payment Crosswalk for CY 2007 Separately Payable Radiopharmaceuticals

2005 HCPCS	Description	2007 HCPCS	Description	2005 Days	2005 Units	CY 2007 Proposed Payment Rate	CY 2007 Proposed Payment Crosswalk
A4642	Supply of satumomab pendetide, radiopharmaceutical diagnostic imaging agent, per dose	A4642	Indium in-111 satumomab pendetide, diagnostic, per study dose, up to 6 millicuries	557	613	$192.12	Unit cost
A9500	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99m sestamibi, per dose	A9500	Technetium tc-99m sestamibi, diagnostic, per study dose, up to 40 millicuries	380,256	608,483	$82.58	Unit cost
A9502	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99m tetrofosmin, per unit dose	A9502	Technetium tc-99m tetrofosmin, diagnostic, per study dose, up to 40 millicuries	222,588	353,488	$73.81	Unit cost
A9505	Supply of radiopharmaceutical diagnostic imaging agent, thallous chloride tl 201, per mci	A9505	Thallium tl-201 thallous chloride, diagnostic, per millicurie	132,448	407,956	$27.18	Unit cost
A9507	Supply of radiopharmaceutical diagnostic imaging agent, indium in 111 capromab pendetide, per dose	A9507	Indium in-111 capromab pendetide, diagnostic, per study dose, up to 10 millicuries	2,109	2,109	$928.19	Unit cost
A9508	Supply of radiopharmaceutical diagnostic imaging agent, iobenguane sulfate i-131, per 0.5 mci	A9508	Iodine i-131 iobenguane sulfate, diagnostic, per 0.5 millicurie	423	593	$429.55	Unit cost
A9516	Supply of radiopharmaceutical diagnostic imaging agent, i-123 sodium iodide capsule, per 100 uci	A9516	Iodine i-123 sodium iodide capsule(s), diagnostic, per 100 microcuries	32,098	73,760	$27.44	Unit cost
A9517	Supply of radiopharmaceutical therapeutic imaging agent, i-131 sodium iodide capsule, per mci	A9517	Iodine i-131 sodium iodide capsule(s), therapeutic, per millicurie	9,836	231,507	$14.54	Unit cost

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2005 HCPCS	Description	2007 HCPCS	Description	2005 Days	2005 Units	CY 2007 Proposed Payment Rate	CY 2007 Proposed Payment Crosswalk
A9521	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc-99m exametazine, per dose	A9521	Technetium tc-99m exametazime, diagnostic, per study dose, up to 25 millicuries	4,258	4,355	$317.07	Unit cost
A9524	Supply of radiopharmaceutical diagnostic imaging agent, iodinated i-131 serum albumin, 5 microcuries	A9524	Iodine i-131 iodinated serum albumin, diagnostic, per 5 microcuries	356	1,543	$36.78	Unit cost
A9526	Supply of radiopharmaceutical diagnostic imaging agent, ammonia n-13, per dose	A9526	Nitrogen n-13 ammonia, diagnostic, per study dose, up to 40 millicuries	63	80	$230.77	Unit cost
A9528	Supply of radiopharmaceutical diagnostic agent, i-131 sodium iodide capsule, per millicurie	A9528	Iodine i-131 sodium iodide capsule(s), diagnostic, per millicurie	4,246	20,556	$24.86	Unit cost
A9530	Supply of radiopharmaceutical therapeutic agent, i-131 sodium iodide solution, per millicurie	A9530	Iodine i-131 sodium iodide solution, therapeutic, per millicurie	1,931	66,609	$12.60	Unit cost
A9511	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99m, depreotide, per mci	A9536	Technetium tc-99m depreotide, diagnostic, per study dose, up to 35 millicuries	582	777	$67.91	Per Day Cost
A9515	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc-99m pentetate, per mci	A9539	Technetium tc-99m pentetate, diagnostic, per study dose, up to 25 millicuries	18,523	211,597	$56.77	Per Day Cost
C1082	Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose	A9542	Indium in-111 ibritumomab tiuxetan, diagnostic, per study dose, up to 5 millicuries	384	384	$1,344.34	Unit cost

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2005 HCPCS	Description	2007 HCPCS	Description	2005 Days	2005 Units	CY 2007 Proposed Payment Rate	CY 2007 Proposed Payment Crosswalk
C1083	Supply of radiopharmaceutical therapeutic imaging agent, yttrium 90 ibritumomab tiuxetan, per dose	A9543	Yttrium y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	362	362	$12,130.20	Unit cost
C1080	Supply of radiopharmaceutical diagnostic imaging agent, i-131 tositumomab, per dose	A9544	Iodine i-131 tositumomab, diagnostic, per study dose	249	249	$1,368.17	Unit cost
C1081	Supply of radiopharmaceutical therapeutic imaging agent, i-131 tositumomab, per dose	A9545	Iodine i-131 tositumomab, therapeutic, per treatment dose	191	191	$11,868.78	Unit cost
C1079	Supply of radiopharmaceutical diagnostic imaging agent, cyanocobalamin co 57/58, per 0.5 microcurie	A9546	Cobalt co-57/58, cyanocobalamin, diagnostic, per study dose, up to 1 microcurie	125	2,401	$149.44	Per Day Cost
C1091	Supply of radiopharmaceutical diagnostic imaging agent, indium 111 oxyquinoline, per 0.5 millicurie	A9547	Indium in-111 oxyquinoline, diagnostic, per 0.5 millicurie	4,296	4,591	$306.51	Unit cost
C1092	Supply of radiopharmaceutical diagnostic imaging agent, indium 111 pentetate, per 0.5 millicurie	A9548	Indium in-111 pentetate, diagnostic, per 0.5 millicurie	5,065	6,381	$262.81	Unit cost
C1122	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99m arcitumomab, per vial	A9549	Technetium tc-99m arcitumomab, diagnostic, per study dose, up to 25 millicuries	145	145	$255.95	Unit cost
Q3006	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99m glucepatate, per 5 mci	A9550	Technetium tc-99m sodium gluceptate, diagnostic, per study dose, up to 25 millicurie	58	72	$236.53	Per Day Cost

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2005 HCPCS	Description	2007 HCPCS	Description	2005 Days	2005 Units	CY 2007 Proposed Payment Rate	CY 2007 Proposed Payment Crosswalk
C1200	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99m sodium glucoheptonate, per vial	A9550	Technetium tc-99m sodium gluceptate, diagnostic, per study dose, up to 25 millicurie	48	48	N/A	N/A
C1201	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99m succimer, per vial	A9551	Technetium tc-99m succimer, diagnostic, per study dose, up to 10 millicuries	447	447	$84.79	Unit cost
C1775	Supply of radiopharmaceutical diagnostic imaging agent, fluorodeoxyglucose f18 (2-deoxy-2-[18f]fluoro-d-glucose), per dose (4-40 mci/ml)	A9552	Fluorodeoxyglucose f-18 fdg, diagnostic, per study dose, up to 45 millicuries	136,012	136,012	$235.56	Unit cost
C9000	Injection, sodium chromate cr51, per 0.25 mci	A9553	Chromium cr-51 sodium chromate, diagnostic, per study dose, up to 250 microcuries	438	488	$167.62	Per Day Cost
C9102	Supply of radiopharmaceutical diagnostic imaging agent, 51 sodium chromate, per 50 mci	A9553	Chromium cr-51 sodium chromate, diagnostic, per study dose, up to 250 microcuries	279	326	N/A	N/A
Q3000	Supply of radiopharmaceutical diagnostic imaging agent, rubidium rb-82, per dose	A9555	Rubidium rb-82, diagnostic, per study dose, up to 60 millicuries	2,059	3,837	$239.83	Unit cost
Q3002	Supply of radiopharmaceutical diagnostic imaging agent, gallium ga 67, per mci	A9556	Gallium ga-67 citrate, diagnostic, per millicurie	3,597	15,880	$22.73	Unit cost
Q3003	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc99m bicisate, per unit dose	A9557	Technetium tc-99m bicisate, diagnostic, per study dose, up to 25 millicuries	1,622	1,652	$254.46	Unit cost
C9013	Supply of co 57 cobaltous chloride, radiopharmaceutical diagnostic imaging agent	A9559	Cobalt co-57 cyanocobalamin, oral, diagnostic, per study dose, up to 1 microcurie	3	3	N/A	N/A

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2005 HCPCS	Description	2007 HCPCS	Description	2005 Days	2005 Units	CY 2007 Proposed Payment Rate	CY 2007 Proposed Payment Crosswalk
Q3012	Supply of oral radiopharmaceutical diagnostic imaging agent, cyanocobalamin cobalt co57, per 0.5 mci	A9559	Cobalt co-57 cyanocobalamin, oral, diagnostic, per study dose, up to 1 microcurie	112	112	$63.74	Per Day Cost
Q3010	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc99m - labeled red blood cells, per mci	A9560	Technetium tc-99m labeled red blood cells, diagnostic, per study dose, up to 30 millicuries	20,662	274,695	$132.95	Per Day Cost
Q3005	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc-99m mertiatide, per mci	A9562	Technetium tc-99m mertiatide, diagnostic, per study dose, up to 15 millicuries	23,306	120,392	$180.08	Per Day Cost
Q3007	Supply of radiopharmaceutical diagnostic imaging agent, sodium phosphate p32, per mci	A9563	Sodium phosphate p-32, therapeutic, per millicurie	307	623	$117.11	Unit cost
Q3011	Supply of radiopharmaceutical diagnostic imaging agent, chromic phosphate p32 suspension, per mci	A9564	Chromic phosphate p-32 suspension, therapeutic, per millicurie	23	87	$222.35	Unit cost
Q3008	Supply of radiopharmaceutical diagnostic imaging agent, indium 111-in pentetreotide, per 3 mci	A9565	Indium in-111 pentetreotide, diagnostic, per millicurie	2,856	4,546	$185.60	Unit cost
C1093	Supply of radiopharmaceutical diagnostic imaging agent, technetium tc 99m fanolesomab, per dose (10 - 20 mci)	A9566	Technetium tc-99m fanolesomab, diagnostic, per study dose, up to 25 millicuries	1,123	1,123	$527.31	Unit cost
A9600	Supply of therapeutic radiopharmaceutical, strontium-89 chloride, per mci	A9600	Strontium sr-89 chloride, therapeutic, per millicurie	519	1,311	$533.58	Unit cost
A9605	Supply of therapeutic radiopharmaceutical, samarium sm 153 lexidronamm, 50 mci	A9605	Samarium sm-153 lexidronamm, therapeutic, per 50 millicuries	959	1,631	$1,316.41	Unit cost

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We specifically request public comment on the radiopharmaceutical payment methodology that we are proposing for the CY 2007 OPPS update. We also seek public comment on the possibility of developing an alternative packaging threshold for radiopharmaceuticals to provide greater administrative simplicity for hospitals. Additionally, we request public comment on the crosswalk that we are proposing to use to determine the CY 2007 payment rates for separately payable radiopharmaceuticals.

While payments for drugs, biologicals and radiopharmaceuticals are taken into account when calculating budget neutrality, we note that we are proposing to make payments for drugs, biologicals, and radiopharmaceuticals without scaling these payment amounts.

Section 1833(t)(14)(A)(iii)(I) requires that, beginning in CY 2006, we pay for a separately payable drug on the basis of ''the average acquisition cost of the drug.'' As we stated in the CY 2006 OPPS final rule with comment period (70 FR 42728), we believe that the best interpretation of the specific requirement that we pay for such drugs on the basis of average acquisition cost, is that these payments themselves should not be adjusted as part of meeting the statutory budget neutrality requirement. If we were to apply a budget neutrality scalar to these payments, we would no longer be paying the average acquisition cost, but rather an adjusted average acquisition cost, for separately payable drugs, biologicals, and radiopharmaceuticals. We believe that these amounts, without a budget neutrality scalar applied, are the best proxies we have for the aggregate average acquisition and pharmacy overhead and handling costs of drugs, biologicals, and radiopharmaceuticals.

b. Proposed CY 2007 Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without OPPS Hospital Claims Data

Pub. L. 108–173 does not address the OPPS payment in CY 2005 and after for new drugs, biologicals, and radiopharmaceuticals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals. Because there is no statutory provision that dictated payment for such drugs and biologicals in CY 2005, and because we had no hospital claims data to use in establishing a payment rate for them, we investigated several payment options for CY 2005 and discussed them in detail in the CY 2005 OPPS final rule with comment period (69 FR 65797 through 65799).

For CYs 2005 and 2006, we finalized the policy to pay separately for new drugs, biologicals, and radiopharmaceuticals with HCPCS codes, but which did not have pass-through status at a rate that was equivalent to the payment they received in the physician office setting, which was established in accordance with the ASP methodology. For CY 2007, we are proposing to continue payment for these new drugs and biologicals with HCPCS codes as of January 1, 2007, but which do not have pass-through status, at a rate that is equivalent to the payment they would receive in the physician office setting, which would be established in accordance with the ASP methodology described in the CY 2006 Medicare Physician Fee Schedule final rule, where payment would generally be equal to ASP+6 percent. In accordance with the ASP methodology, in the absence of ASP data, we are continuing the policy we implemented during CYs 2005 and 2006 of using the wholesale acquisition cost (WAC) for the product to establish the initial payment rate. We note, however, that if the WAC is also unavailable, we would make payment at 95 percent of the product's most recent AWP. We are proposing to adopt this interim payment methodology in order to be consistent with how we pay for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes, as discussed in the CY 2006 OPPS final rule with comment period (70 FR 68669). We further note that with respect to items for which we do not have ASP data, once their ASP data become available in later quarter submissions, their payment rates under OPPS will be adjusted so that the rates are based on the ASP methodology and set to ASP+6 percent. In the event that the drug or biological is covered under the competitive acquisition program, then we propose to pay for it at the payment rate calculated under this program consistent with the provisions in section 1847B of the Act. We propose to base payment for new radiopharmaceuticals with HCPCS codes as of January 1, 2007, but which do not have pass-through status, on the WACs for these products as ASP data for radiopharmaceuticals are not available. In addition, we note that if the WACs are also unavailable, then we would make payment for the radiopharmaceuticals at 95 percent of their most recent AWPs. We are proposing to adopt this interim payment methodology in order to be consistent with how we pay for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes, as discussed in the CY 2006 OPPS final rule with comment period (70 FR 68669). To be consistent with the ASP-based payments that would be made when the new drugs and biologicals are furnished in physician offices, we are proposing to make any appropriate adjustments to their payment amounts in the CY 2007 OPPS final rule and also on a quarterly basis on our Web site during CY 2007 if later quarter ASP submissions (or more recent WACs or AWPs) indicate that adjustments to the payment rates for these drugs and biologicals are necessary. The payment rates for new radiopharmaceuticals would also be adjusted accordingly. We are also proposing to make appropriate adjustments to the payment rates for new drugs and biologicals in the event that they become covered under the competitive acquisition program in the future.

As discussed in the CY 2005 OPPS final rule with comment period (69 FR 65797), and the CY 2006 OPPS final rule with comment period (70 FR 68666), new drugs, biologicals, and radiopharmaceuticals may be expensive, and we are concerned that packaging these new items might jeopardize beneficiary access to them. In addition, we do not want to delay separate payment for these items solely because a pass-through application was not submitted. The payment methodologies described above are the same as the methodologies that would be used to calculate the OPPS payment amount that pass-through drugs, biologicals, and radiopharmaceuticals would be paid in CY 2007. We refer readers to section V.A. of this preamble for a discussion of payment policies of pass-through drugs, biologicals, and radiopharmaceuticals under OPPS. Consequently, we are proposing to continue to treat new drugs, biologicals, and radiopharmaceuticals with newly established HCPCS codes the same, irrespective of whether pass-through status has been determined. We also are proposing to assign status indicator ''K'' to HCPCS codes for new drugs, biologicals, and radiopharmaceuticals for which we have not received a pass-through application. We specifically request comments on our proposed payment policies for new drugs, biologicals, and radiopharmaceuticals with HCPCS codes but which do not have pass-through status as of January 1, 2007. The new CY 2007 HCPCS codes for drugs, biologicals, and radiopharmaceuticals are not available at the time of the development of this proposed rule; however, they will be included in the CY 2007 OPPS final rule.

There are several drugs, biologicals, and radiopharmaceuticals that were payable during CY 2005 or where HCPCS codes for products were created effective January 1, 2006, for which we do not have any CY 2005 hospital claims data. In order to determine the packaging status of these items for CY 2007, we calculated an estimate of the per day cost of each of these items by multiplying the payment rate for each product based on ASP+5 percent similar to other separately payable nonpass-through drugs and biologicals under the OPPS and, as determined using the ASP methodology as described in section V.B.3.a.2. of this preamble, by an estimated average number of units of each product that would typically be

furnished to a patient during one administration in the hospital outpatient setting. We are proposing to package items for which we estimate the per administration cost to be less than $55, which is the packaging threshold that we are proposing for drugs, biologicals, and radiopharmaceuticals in CY 2007, and pay separately for items with an estimated per administration cost greater than $55. We are proposing that the CY 2007 payment for separately payable items would be based on rates determined using the ASP methodology established in the physician office setting and set to ASP+5 percent, similar to other separately payable nonpass-through drugs and biologicals under the OPPS. In accordance with the ASP methodology used in the physician office setting, in the absence of ASP data, we would use the WAC for the product to establish the initial payment rate. We note, however, that if the WAC is also unavailable, then we would make payment at 95 percent of the most recent AWP available. We note that for radiopharmaceutical agents that do not have any CY 2005 hospital claims data, we propose to determine their packaging status and, if the items are separately payable, then establish their payment rates using the WACs for the products because ASP data are not available for any radiopharmaceuticals. We also note that if the WACs are unavailable, then we would use payment at 95 percent of the most recent AWPs to determine their packaging status and payment rates. In order to determine the packaging status and payment rates for these drugs, biologicals, and radiopharmaceuticals in this proposed rule, we used ASP data from the fourth quarter of 2005 or the most recent WAC or AWP data available at this time, as appropriate.

Table 27 below lists all of the items without available CY 2005 claims data to which these policies would apply in CY 2007. There are three HCPCS codes for which we were not able to determine payment rates based on the ASP methodology. The HCPCS codes are 90393 (Vaccina ig, im), 90693 (Typhoid vaccine, akd, sc), and A9567 (Technitium TC-99m aerosol). Because we are unable to estimate the per administration cost of these items, we are proposing to package them in CY 2007. We are seeking comments on our proposed policies for determining the per administration cost of the drugs, biologicals, and radiopharmaceuticals that are payable under the OPPS, but do not have any CY 2005 claims data.

TABLE 27.—DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS WITHOUT CY 2005 CLAIMS DATA

HCPCS code	Description	ASP-based payment rate	Estimated average number of units per administration	CY 2007 proposed SI
90714	Td vaccine no prsrv >/= 7 im	$18.09	1	N
90727	Plague vaccine, im	150.00	1	K
A9535	Injection, methylene blue	2.87	10	N
J0132	Acetylcysteine injection	1.86	210	K
J0200	Alatrofloxacin mesylate	16.03	2.5	N
J0278	Amikacin sulfate injection	1.33	5.25	N
J0288	Ampho b cholesteryl sulfate	12.00	35	K
J0350	Injection anistreplase 30 u	2,265.46	1	K
J0395	Arbutamine HCl injection	160.00	1	K
J1452	Intraocular Fomivirsen na	210.00	1	K
J2425	Palifermin injection	11.37	84	K
J2805	Sincalide injection	44.14	1	N
J2850	Inj secretin synthetic human	20.31	14	K
J3355	Urofollitropin, 75 iu	48.84	2	K
J3471	Ovine, up to 999 USP units	0.11	150	N
J3472	Ovine, 1000 USP units	133.77	1	K
J7341	Non-human, metabolic tissue	1.64	50	K
J8540	Oral dexamethasone	0.07	80	N
J9225	Histrelin implant	2,019.82	1	K
Q9958	HOCM ≤ 149 mg/ml iodine, 1ml	0.06	100	N
Q9959	HOCM 150–199mg/ml iodine,1ml	0.08	100	N
Q9960	HOCM 200–249mg/ml iodine,1ml	0.09	100	N
Q9961	HOCM 250–299mg/ml iodine,1ml	0.17	100	N
Q9962	HOCM 300–349mg/ml iodine,1ml	0.14	100	N
Q9963	HOCM 350–399mg/ml iodine,1ml	0.39	100	N
Q9964	HOCM ≥ 400mg/ml iodine, 1ml	0.19	100	N

VI. Proposed Estimate of OPPS Transitional Pass-Through Spending in CY 2007 for Drugs, Biologicals, Radiopharmaceuticals, and Devices

(If you choose to comment on issues in this section, please include the caption ''OPPS: Estimated Transitional Pass-Through Spending'' at the beginning of your comment.)

A. Total Allowed Pass-Through Spending

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for drugs, biologicals, radiopharmaceuticals, and categories of devices for a given year to an ''applicable percentage'' of projected total Medicare and beneficiary payments under the hospital OPPS. For a year before CY 2004, the applicable percentage was 2.5 percent; for CY 2004 and subsequent years, we specify the applicable percentage up to 2.0 percent.

If we estimate before the beginning of the calendar year that the total amount of pass-through payments in that year would exceed the applicable percentage, section 1833(t)(6)(E)(iii) of the Act requires a uniform reduction in the amount of each of the transitional pass-through payments made in that year to ensure that the limit is not exceeded. We make an estimate of pass-through spending to determine not only whether

payments exceed the applicable percentage, but also to determine the appropriate reduction to the conversion factor for the projected level of pass-through spending in the following year.

For devices, making an estimate of pass-through spending in CY 2007 entails estimating spending for two groups of items. The first group consists of those items for which we have claims data for procedures that we believe used devices that were eligible for pass-through status in CY 2005 and CY 2006 and that would continue to be eligible for pass-through payment in CY 2007. The second group consists of those items for which we have no direct claims data, that is, items that became, or would become, eligible in CY 2006 and would retain pass-through status in CY 2007, as well as items that would be newly eligible for pass-through payment beginning in CY 2007.

B. Proposed Estimate of Pass-Through Spending for CY 2007

We are proposing to set the applicable percentage cap at 2.0 percent of the total OPPS projected payments for CY 2007. As we discuss in section IV.B. of this preamble, there is one device category receiving pass-through payment in CY 2006 that will continue for payment during CY 2007. Therefore, we estimate pass-through spending attributable to the first group of items described above to be $36.8 million.

To estimate CY 2007 pass-through spending for device categories in the second group, that is, items for which we have no direct claims data, we used the following approach: For additional device categories that are approved for pass-through status after July 1, 2006, but before January 1, 2007, we are proposing to use price information from manufacturers and volume estimates based on claims for procedures that would most likely use the devices in question because we do not have any CY 2005 claims data upon which to base a spending estimate. We are proposing to project these data forward to CY 2007 using inflation and utilization factors based on total growth in OPPS services as projected by CMS' Office of the Actuary (OACT) to estimate CY 2007 pass-through spending for this group of device categories. We may use an alternate growth factor for any specific new device category based on our claims data or the device's clinical characteristics, or both. For device categories that become eligible for pass-through status in CY 2007, we are proposing to use the same methodology. We anticipate that any new categories for January 1, 2007, would be announced after the publication of this proposed rule, but before publication of the final rule with comment period. Therefore, the estimate of pass-through spending in the CY 2007 OPPS final rule with comment period would incorporate any pass-through spending for device categories made effective January 1, 2007, and during subsequent quarters of CY 2007.

With respect to CY 2007 pass-through spending for drugs and biologicals, as we explain in section V.A.3. of this proposed rule, the pass-through payment amount for new drugs and biologicals that we determine have pass-through status will equal zero. Therefore, our estimate of pass-through spending for drugs and biologicals with pass-through status in CY 2007 equals zero.

In the CY 2005 OPPS final rule with comment period (69 FR 65810), we indicated that we are accepting pass-through applications for new radiopharmaceuticals that are assigned a HCPCS code on or after January 1, 2005. (Prior to this date, radiopharmaceuticals were not included in the category of drugs paid under the OPPS, and therefore, were not eligible for pass-through status.) We have no new radiopharmaceuticals that were added for pass-through payment in CY 2005 or to this point in CY 2006, and we currently have no information identifying new radiopharmaceuticals to which a HCPCS code might be assigned on or after January 1, 2007, for which pass-through payment status would be sought. We also have no data regarding payment for new radiopharmaceuticals with pass-through status under the methodology that we specified in the CY 2005 OPPS final rule with comment period. However, we do not believe that pass-through spending for new radiopharmaceuticals in CY 2007 will be significant enough to materially affect our estimate of total pass-through spending in CY 2007. Therefore, we are not including radiopharmaceuticals in our estimate of pass-through spending for CY 2007. We discuss the methodology for determining the proposed CY 2007 payment amount for radiopharmaceuticals with pass-through status in section V.B.3.b. of this preamble.

In accordance with the methodology described above, we estimate that total pass-through spending for both device categories that are continuing into CY 2007 and that first become eligible for pass-through status during CY 2007 would equal approximately $43.2 million, which represents 0.13 percent of total OPPS projected payments for CY 2007. This figure includes estimates for the current device category continuing into CY 2007, which equals $36.8 million, in addition to projections for categories that may become eligible after publication of this proposed rule but before the end of CY 2006, and for projections for new categories that may become eligible during CY 2007.

TABLE 28.—ESTIMATES FOR CY 2007 TRANSITIONAL PASS-THROUGH SPENDING FOR CURRENT PASS-THROUGH CATEGORIES CONTINUING INTO CY 2007

HCPCS	APC	Existing pass-through device category	CY 2007 estimated utilization	CY 2007 estimated pass-through payments
C1820	1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system	4,568	$36,766,720

Because we estimate pass-through spending in CY 2007 will not amount to 2.0 percent of total projected OPPS CY 2007 spending, we are proposing to return 1.87 percent of the pass-through pool to adjust the conversion factor, as we discuss in section II.C. of this preamble.

VII. Proposed Brachytherapy Source Payment Changes

(If you choose to comment on issues in this section, please include the caption ''OPPS: Brachytherapy'' at the beginning of your comment.)

A. Background

Section 1833(t)(2)(H) of the Act, as added by section 621(b)(2)(C) of Pub. L. 108–173, mandated the creation of separate groups of covered OPD services that classify brachytherapy devices separately from other services or groups of services. The additional groups must

reflect the number, isotope, and radioactive intensity of the devices of brachytherapy furnished, including separate groups for Palladium-103 and Iodine-125 devices. In accordance with this provision, since CY 2004 we have established four new brachytherapy source codes and descriptors.

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

In the OPPS interim final rule with comment period published on January 6, 2004 (69 FR 827), we implemented sections 621(b)(1) and (b)(2)(C) of Pub. L. 108–173. In that rule, we stated that we would pay for the brachytherapy sources listed in Table 4 of the interim final rule with comment period (69 FR 828) on a cost basis, as required by the statute. Since January 1, 2004, we have used status indicator ''H'' to denote nonpass-through brachytherapy sources paid on a cost basis, a policy that we finalized in the CY 2005 final rule with comment period (69 FR 65838).

Furthermore, we adopted a standard policy for brachytherapy code descriptors, beginning January 1, 2005. We included ''per source'' in the HCPCS code descriptors for all those brachytherapy source descriptors for which units of payment were not already delineated.

Section 621(b)(3) of Pub. L. 108–173 requires the Government Accountability Office (GAO) to conduct a study to determine appropriate payment amounts for devices of brachytherapy, and to submit a report on its study to the Congress and the Secretary, including recommendations. The GAO's final report, published at the end of July 2006, was not available in time to review and discuss in this proposed rule. We plan to discuss the report's findings and recommendations in the CY 2007 OPPS final rule with comment period.

B. Proposed Payments for Brachytherapy Sources in CY 2007

As indicated above, the provision to pay for brachytherapy sources at charges reduced to cost expires after December 31, 2006, in accordance with section 1833(t)(16)(C) of the Act. However, under section 1833(t)(2)(H) of the Act, we are still required to create APC groupings that classify devices of brachytherapy separately from other services or groups of services in a manner reflecting the number, isotope, and radioactive intensity of the devices of brachytherapy furnished.

We are proposing to pay separately for each of the sources listed in Table 29 below on a prospective basis for CY 2007, with payment rates to be determined using the CY 2005 claims-based median cost per source for each brachytherapy device. Consistent with our policy regarding APC payments made on a prospective basis, we are proposing that the cost of brachytherapy sources be subject to the outlier provisions of section 1833(t)(5) of the Act. As indicated in section II.A.2. of the preamble to this proposed rule, for CY 2007, we are proposing a specific payment rate for brachytherapy sources, which will be subject to scaling for budget neutrality.

Table 29 includes a complete listing of the HCPCS codes, long descriptors, APC assignments, APC titles, and status indicators that we currently use for brachytherapy sources paid under the OPPS in CY 2006 and that we are proposing to use for CY 2007. The brachytherapy sources and related information in Table 29 are the same sources and information as those listed in Table 28 of the OPPS CY 2006 final rule with comment period (70 FR 68676). No additional brachytherapy sources have been added since the CY 2006 final rule with comment period.

TABLE 29.—PROPOSED SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2007

HCPCS code	Long descriptor	APC	APC title	New status indicator
C1716	Brachytherapy source, Gold 198, per source	1716	Brachytx source, Gold 198	K
C1717	Brachytherapy source, High Dose Rate Iridium 192, per source.	1717	Brachytx source, HDR Ir-192	K
C1718	Brachytherapy source, Iodine 125, per source	1718	Brachytx source, Iodine 125	K
C1719	Brachytherapy source, Non-High Dose Rate Iridium 192, per source.	1719	Brachytx source, Non-HDR Ir-192	K
C1720	Brachytherapy source, Palladium 103, per source	1720	Brachytx source, Palladium 103	K
C2616	Brachytherapy source, Yttrium-90, per source	2616	Brachytx source, Yttrium-90	K
C2632	Brachytherapy solution, Iodine125, per mCi	2632	Brachytx sol, I-125, per mCi	K
C2633	Brachytherapy source, Cesium-131, per source	2633	Brachytx source, Cesium-131	K
C2634	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	Brachytx source, HA, I-125	K
C2635	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	Brachytx source, HA, P-103	K
C2636	Brachytherapy linear source, Palladium-103, per 1MM	2636	Brachytx linear source, P-103	K
C2637	Brachytherapy source, Ytterbium-169, per source	2637	Brachytx, Ytterbium-169	K

There are a number of advantages to this proposed payment method. The OPPS is a prospective payment system under which payment rates are generally established based on median costs from historical hospital claims. Therefore, under this payment method, brachytherapy sources would be paid using the same basic median cost methodology as the overall OPPS. The payment of sources would thus be an integral part of the OPPS, rather than a separate cost-based payment methodology within the OPPS. In addition, consistent and predictable prospectively established payment rates under the OPPS for brachytherapy sources are appropriate because we do not believe that the hospital resource costs associated with specific brachytherapy sources should vary

greatly across hospitals or across clinical conditions under treatment, other than through differences in the numbers of sources utilized, which are already accounted for in our per source payment methodology. This prospective payment methodology would promote efficiency in the provision of sources, while continuing to provide payments that reflect the wide clinical variation in the use of brachytherapy sources related to many factors, including tumor type and stage, patient anatomy, and planned brachytherapy dose. In addition, under this method, we would continue to pay for brachytherapy sources separately using the same C-codes and descriptors that hospitals have reported for the last several years.

We note that High Dose Rate (HDR) Iridium-192 (C1717) is a reusable source, across treatment sessions and across patients. It is unclear whether hospitals are reporting the number of units provided accurately. Thus, while we are currently proposing that HDR Iridium be paid separately on the basis of the median cost per source as we are proposing to pay for the other brachytherapy sources, we invite comments on alternatives to using this methodology for this source, such as on the basis of median costs per treatment day on hospital claims.

During the March 1–2, 2006 APC Panel meeting, we discussed median cost data for brachytherapy sources developed from the partial CY 2005 hospitals claims data available for analysis at the time of the meeting. While the APC Panel made no specific recommendations about a specific OPPS CY 2007 payment methodology for brachytherapy sources, the Panel reviewed the median costs for the sources of brachytherapy and generally commented that the median costs appeared reasonable for the commonly furnished brachytherapy sources.

Because brachytherapy sources would no longer be paid on the basis of their charges reduced to costs, we are proposing to discontinue our use of payment status indicator ''H'' for APCs assigned to brachytherapy sources. We are proposing to use status indicator ''K'' for all brachytherapy source APCs for CY 2007. We are also proposing for CY 2007 to change the definition of status indicator ''K'' to ensure that ''K'' appropriately describes brachytherapy source APCs. Payment status indicators are discussed in section XV.A. of this preamble.

There is one source for which we have no claims data or payment information. We added Ytterbium-169 (HCPCS code C2637) for payment effective October 1, 2005, because it met the requirements of section 1833(t)(2)(H) of the Act as a separate brachytherapy source. It is our understanding that this source, which is for use in high dose rate (HDR) brachytherapy, is not yet marketed by the manufacturer, although it has been approved by the Food and Drug Administration (FDA). Therefore, we have no claims data for this brachytherapy source in order to develop a prospective payment rate, as we do for the other brachytherapy sources for CY 2007. In addition, it is our understanding that no price for the product exists, as it has not yet been marketed. Thus, we also have no external information regarding the cost of this source to hospitals. We are weighing our payment options for CY 2007 for brachytherapy sources for which we have no payment or claims information, such as the present case with Ytterbium-169. This includes considering our CY 2007 payment options for other new brachytherapy sources that come to our attention, which historically have been newly recognized under the OPPS on a quarterly basis.

One option for CY 2007 would be to pay for the currently existing HCPCS code C2637 at charges converted to costs. However, this would be inconsistent with our proposed policy with regard to payment for brachytherapy sources under prospectively established payment rates. We paid for all brachytherapy sources based upon charges converted to costs for CYs 2004 through 2006 because the law required us to do so. However, that provision will expire for the CY 2007 OPPS. In addition, this methodology would be inconsistent with the prospective payment methodologies we use to provide payments for other new items and services under the OPPS for which we do not yet have claims data.

A second option would be to assign the code to its own APC or to a New Technology APC with a payment rate set at or near the lowest proposed payment rate for any source of brachytherapy paid on a per source basis (as opposed, for example, per mCi), for CY 2007. However, we have no claims data or other information regarding the cost of HCPCS code C2637 to hospitals. This payment policy would resemble our policy regarding the APC assignment of not otherwise classified codes, which are assigned to the lowest level APC in their clinically compatible series. However, HCPCS code C2637 is a specifically defined brachytherapy source, and such a payment rate would not recognize the clinical distinctions among brachytherapy sources, including their differences in isotopes, activity levels, and clinical uses in low dose rate (LDR) versus HDR brachytherapy. The solid brachytherapy source with the lowest proposed median cost for CY 2007 is HCPCS code C2634, for High Activity Iodine-125, with a median cost of $25.77 per source, which is implanted in LDR brachytherapy.

A third option would be to assign HCPS code C2637 to its own APC or to a New Technology APC with a payment rate established at or near the proposed payment rate for HCPCS code C1717, which describes HDR Iridium-192. Like HCPCS code C2637, HCPCS code C1717 is used for HDR brachytherapy, and HCPCS code C1717 is the most commonly used source for HDR brachytherapy under the OPPS. However, this approach would not take into consideration significant differences in the two sources, including their radioactive isotopes and energy levels.

The fourth option would be to assign HCPCS code C2637 to its own APC or to a New Technology APC with a prospective payment rate based on external data provided to us regarding the expected cost of the source to hospitals. If we were provided reliable and relevant cost information for the source, we could establish its payment rate based on that information and our review of other pertinent considerations, as we do for new technology services under the OPPS. Under this option, in the absence of external cost information, we would not recognize HCPCS code C2637 under the OPPS for CY 2007 until we received such information and could establish a payment rate in a quarterly OPPS update. CMS provided the brachytherapy source Ytterbium-169 a HCPCS code in CY 2005 at the manufacturer's request, based on the belief that the source would be marketed shortly. However, the product has not yet been marketed. Therefore, we currently have a recognized HCPCS code for an item that is not currently available to hospitals. We do not typically issue and maintain as payable a HCPCS code for an item that is not marketed. Under this option, if the source were marketed mid-quarter in CY 2007 and cost information was provided to us, there would be no payment available for the source until the next OPPS quarterly update, which would establish the payment rate for HCPCS code C2637 and its effective date.

After weighing the above options, we are proposing the second option discussed, that is, to assign C2637 to its own APC or a New Technology APC with a payment rate set at or near the lowest proposed payment rate for any

source of brachytherapy paid on a per source basis. This option resembles our policy regarding the APC assignment of not otherwise classified codes, in the absence of any data currently available. Once we have claims data, or obtain external data, we can consider movement to another APC, if warranted. However, as we indicate below, we are interested in the public's comments on the four options we have presented.

We are specifically inviting comments on how we should establish the CY 2007 payment amount for Ytterbium-169 (HCPCS code C2637), especially with consideration of the four options discussed above, and on how we should generally proceed on setting payment amounts for established or new brachytherapy sources eligible for separate payment under section 1833(t)(2)(H) of the Act, for which we have no claims-based cost data in the future. Note that under option 4, for a future new source we would need cost information regarding the source in order to establish a code for which we could set an appropriate OPPS payment rate. We intend to avoid routinely establishing HCPCS codes for brachytherapy sources which hospitals could not be using, and, therefore, for which payments would not be necessary.

As we have consistently done in the past, we are inviting the public to submit recommendations for new codes to describe new brachytherapy sources in a manner reflecting the number, isotope, and radioactive intensity of the sources. We are requesting that commenters provide a detailed rationale to support recommended new sources and send recommendations to us. We will continue our endeavor to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly basis. Such recommendations should be directed to the Division of Outpatient Care, Mail Stop C4–05–17, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244.

We have considered the definition of the term ''brachytherapy source'' in the context of current medical practice, and in light of the language in section 1833(t)(2)(H) of the Act. We are proposing to define a device of brachytherapy eligible for separate payment under the OPPS as a ''seed or seeds (or radioactive source)'' as indicated in section 1833(t)(2)(H) of the Act, which refers to sources that are themselves radioactive, meaning that the sources contain a radioactive isotope. Therefore, for example, we do not consider specific devices that do not utilize radioactive isotopes to deliver radiation to be radioactive sources as envisioned by the statute. While the public may recommend any item that it wishes us to consider as a brachytherapy source, we remind the public of our interpretation of a device of brachytherapy eligible for separate payment under section 1833(t)(2)(H) of the Act.

VIII. Proposed Changes to OPPS Drug Administration Coding and Payment for CY 2007

(If you choose to comment on issues in this section, please include the caption ''OPPS: Drug Administration'' at the beginning of your comment.)

A. Background

From the start of the OPPS until the end of CY 2004, three HCPCS codes were used to bill drug administration services provided in the hospital outpatient department:

- Q0081 (Infusion therapy, using other than chemotherapeutic drugs, per visit)
- Q0083 (Chemotherapy administration by other than infusion technique only, per visit)
- Q0084 (Chemotherapy administration by infusion technique only, per visit).

A fourth OPPS drug administration HCPCS code, Q0085 (Administration of chemotherapy by both infusion and another route, per visit), was active from the beginning of the OPPS through the end of CY 2003.

Each of these four HCPCS codes mapped to an APC (that is, Q0081 mapped to APC 0120, Q0083 mapped to APC 0116, Q0084 mapped to APC 0117, and Q0085 mapped to APC 0118), and the APC payment rates for these codes were made on a per-visit basis. The per-visit payment included payment for all hospital resources (except separately payable drugs) associated with the drug administration procedures. For CY 2004, we discontinued using HCPCS code Q0085 to identify drug administration services and moved to a combination of HCPCS codes Q0083 and Q0084 that allowed more accurate calculations when determining OPPS payment rates.

In CY 2005, in response to the recommendations made by commenters and the hospital industry, OPPS transitioned to the use of CPT codes for drug administration services. These CPT codes allowed for more specific reporting of services, especially regarding the number of hours for an infusion, and provided consistency in coding between Medicare and other payers. However, we did not have any data to revise the CY 2005 per-visit APC payment structure for infusion services. In order to collect data for future ratesetting purposes, we implemented claims processing logic that collapsed payments for drug administration services and paid a single APC amount for those services for each visit, unless a modifier was used to identify drug administration services provided in a separate encounter on the same day. Hospitals were instructed to bill all applicable CPT codes for drug administration services provided in a hospital outpatient department, without regard to whether or not the CPT code would receive a separate APC payment during OPPS claims processing.

While hospitals were just adopting CPT codes for outpatient drug administration services in CY 2005, physicians paid under the Medicare Physician Fee Schedule were using HCPCS G-codes in CY 2005 to report office-based drug administration services. These G-codes were developed in anticipation of substantial revisions to the drug administration CPT codes by the CPT Editorial Panel that were expected for CY 2006.

In CY 2006, as anticipated, the CPT Editorial Panel revised its coding structure for drug administration services, incorporating new concepts such as initial, sequential, and concurrent services into a structure that previously distinguished services based on type of administration (chemotherapy/nonchemotherapy), method of administration (injection/infusion/push), and for infusion services, first hour and additional hours. For CY 2006, we proposed a crosswalk that mapped the expected CY 2006 CPT codes (represented by CY 2005 G-codes used in the physician office setting, the closest proxy at the time) to the APC payment structure implemented in CY 2005. Our crosswalk was reviewed by the APC Panel at both the February and August 2005 meetings, and was included in the CY 2006 OPPS proposed rule. During the proposed rule comment period, we received a number of comments that prompted several revisions to our proposed crosswalk, including the development of complex claims processing logic to assign correct payment for certain drug administration services that would vary based on other drug administration services provided during the same patient visit. These revisions were a result of the growing understanding, facilitated by the preview of CPT drug administration coding guidelines developed by the CPT Editorial Panel, in the hospital community of the multiple implications associated with adopting the newly

introduced CPT concepts of initial, sequential, and concurrent services.

Upon review of the completed revisions to our proposed CY 2006 methodology, and following comprehensive assessment of all public comments, we implemented 20 of the 33 CY 2006 drug administration CPT codes that did not reflect the concepts of initial, sequential, and concurrent services, and we created 6 new HCPCS C-codes that generally paralleled the CY 2005 CPT codes for the same services. We chose not to implement the full set of CY 2006 CPT codes because of our concerns regarding the interface between the complex claims processing logic required for correct payments and hospitals' challenges in correctly coding their claims to receive accurate payments for these services. In addition, numerous commenters indicated that implementing certain CPT codes in a fashion consistent with the code descriptors would present hospitals with difficult operational and administrative challenges because concepts integral to the codes were inconsistent with the clinical patterns of drug administration services provided in hospital outpatient departments. In addition to coding changes, CY 2006 payment rates for drug administration services were updated based upon CY 2004 claims, and we continued the claims processing logic that required hospitals providing drug administration services to report all applicable drug administration HCPCS codes, despite some codes being collapsed into one APC for payment purposes.

B. Proposed CY 2007 Drug Administration Coding Changes

For the CY 2007 OPPS, we are proposing to continue the CY 2006 OPPS drug administration coding structure, which combines CPT codes with several C-codes. However, we welcome comments from hospitals regarding their experiences in implementing, for purposes of reporting to other payers, the CY 2006 CPT codes that incorporate the concepts of initial, sequential, and concurrent drug administration services. While we are not proposing to transition to the full set of CPT codes in CY 2007, we retain this as an option for the future.

In addition, because of the discrepancies between APC payments (based on per-visit hospital claims data) and per-service CPT/HCPCS coding, we provided special instructions to hospitals in CY 2005 and CY 2006 regarding modifier 59 in order to ensure proper OPPS payments, consistent with our claims processing logic. As we do not expect any changes to our coding structure for CY 2007 and because we have updated service-specific claims data from CY 2005, we no longer have the need for specific drug administration instructions regarding modifier 59. Instead, for CY 2007 we are proposing that hospitals apply modifier 59 to drug administration services using the same correct coding principles that they generally use for other OPPS services.

C. Proposed CY 2007 Drug Administration Payment Changes

CY 2007 is the first year that we have more detailed claims data to inform our ratesetting process. Through CY 2006, payment for additional hours of drug infusion has always been packaged, although separate codes for reporting these hours have been used under the OPPS since CY 2005. Specifically, hospitals began reporting more precise CPT codes in CY 2005 that included separate coding for the first hour of infusion versus additional hours of infusion. In order to analyze these data, because we expected that additional hours of infusion codes would always be reported with codes for the first hour of infusion, thereby resulting in multiple bills for the additional hours of infusion CPT codes, we added the following three CY 2005 drug administration CPT codes to the bypass list utilized to create ''pseudo'' single claims: CPT codes 90781 (Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; each additional hour, up to eight (8) hours); 96412 (Chemotherapy administration, intravenous; infusion technique, one to 8 hours, each additional hour); and 96423 (Chemotherapy administration, intra-arterial; infusion technique, one to 8 hours, each additional hour). The standard OPPS methodology, as described in section II.A. of this proposed rule, was used to calculate HCPCS medians for these three drug administration codes. We then mapped all the data for the three additional hours of infusion CPT codes from the single and ''pseudo'' single claims to the APCs to which we are proposing to assign the CY 2005 claims data for these codes for purposes of calculating APC median costs.

While bypassing these three CPT codes and developing additional ''per unit'' claims provide a methodology to calculate median costs for these previously packaged drug administration services and to attribute all of their cost data to their assigned APCs, we note that this methodology allocates all packaging on the claim related to drug administration to the associated first hour drug administration code. Because these additional hours of infusion codes are not reported alone in conjunction with other separately payable nondrug administration services, we would not expect that the packaging related to additional hours of infusion would be inappropriately assigned to nondrug administration services. While we realize that there are some packaged costs that truly are clinically related to the second and subsequent hours of infusion, especially for infusions of packaged drugs that span several hours, and would, therefore, be most appropriately allocated to the additional hours of infusion codes, we are not able at this time to accurately assign representative portions of packaging costs to multiple different services at this time due to the limitations of our claims data. We believe this proposed methodology takes into account all of the packaging on claims for drug administration services and provides a reasonable framework for developing median costs for drug administration services that are often provided in combination with one another.

Upon review of the HCPCS median costs for all drug administration services, including injections and antigen therapy services, we created a comprehensive set of new APC groupings of CY 2005 HCPCS codes for drug administration services, with our assignments based both upon hospital resources utilized as reflected in HCPCS median costs and clinical coherence. The result of this analysis was the development of six proposed drug administration APC levels for the proposed CY 2007 payment rates, as shown in Table 30–1.

Table 30-1.--Proposed 6-Level APC Structure of CY 2005 CPT Drug Administration Codes Used to Develop CY 2007 APC Payment Rates

Proposed CY 2007 Drug Administration APC Level	CY 2005 CPT/HCPCS Code	Description	Proposed CY 2007 APC Reflecting Claims Data
LEVEL I	90472	Immunization admin, each add	0436
	90473	Immune admin oral/nasal	
	90474	Immune admin oral/nasal addl	
	90799	Ther/prophylactic/dx inject	
	95115	Immunotherapy, one injection	
	96549	Chemotherapy, unspecified	
LEVEL II	90471	Immunization admin	0437
	90781	IV infusion, additional hour	
	90782	Injection, sc/im	
	90788	Injection of antibiotic	
	95117	Immunotherapy injections	
	95144	Antigen therapy services	
	95145	Antigen therapy services	
	95146	Antigen therapy services	
	95147	Antigen therapy services	
	95148	Antigen therapy services	
	95149	Antigen therapy services	
	95165	Antigen therapy services	
	95170	Antigen therapy services	
	G0008	Admin influenza virus vac	
	G0009	Admin pneumococcal vaccine	
	G0010	Admin hepatitis b vaccine	
LEVEL III	90783	Injection, ia	0438
	90784	Injection, iv	
	96400	Chemotherapy, sc/im	
	96405	Chemo intralesional, up to 7	
	96406	Chemo intralesional over 7	
	96412	Chemo, infuse method add-on	
	96423	Chemo ia infuse each addl hr	
	96542	Chemotherapy injection	
LEVEL IV	96408	Chemotherapy, push technique	0439
	96420	Chemo, ia, push technique	
	96440	Chemotherapy, intracavitary	
	96445	Chemotherapy, intracavitary	
LEVEL V	90780	IV infusion therapy, 1 hour	0440
	96520	Port pump refill & main	
	96530	Syst pump refill & main	
LEVEL VI	96410	Chemotherapy,infusion method	0441
	96414	Chemo, infuse method add-on	
	96422	Chemo ia infusion up to 1 hr	
	96425	Chemotherapy,infusion method	
	96450	Chemotherapy, into CNS	

As shown above, the placement of HCPCS codes into the proposed six levels follows logical, clinically coherent principles and is consistent with both expected and observed differences in hospital resource costs,

both across levels and within each level. For example, the first hour of chemotherapy infusion is assigned to proposed Level VI, while additional hours of chemotherapy infusion are assigned to proposed Level III. This proposed structure is mirrored by the nonchemotherapy codes that show the first hour of nonchemotherapy infusion assigned to proposed Level V, while additional hours of nonchemotherapy infusion are assigned to proposed Level II.

Using this structure as a base, the CY 2006 OPPS drug administration codes were assigned to the proposed 6-level APC structure based on their clinical and expected hospital resource characteristics, as seen in Table 30–2.

This proposed structure was presented to the APC Panel during the March 2006 meeting. The Panel recommended using the bypass methodology as described above for the three additional hours of infusion codes to develop their median costs and supported separate payment for each additional hour of infusion for CY 2007, as shown in Table 30–2.

Table 30-2.--CY 2007 Proposed 6-Level Drug Administration APC Structure

Proposed CY 2007 APC	APC Status Indicator	Proposed CY 2007 APC Median	CPT/HCPCS Code	Description
0436	S	$10.71	90472	Immunization admin, each add
			90473	Immune admin oral/nasal
			90474	Immune admin oral/nasal addl
			90779	Ther/prop/diag inj/inf proc
			95115	Immunotherapy, one injection
			96549	Chemotherapy, unspecified
0437	S	$25.49	90772	Ther/proph/diag inj, sc/im
			90471	Immunization admin
			95117	Immunotherapy injections
			95144	Antigen therapy services
			95145	Antigen therapy services
			95146	Antigen therapy services
			95147	Antigen therapy services
			95148	Antigen therapy services
			95149	Antigen therapy services
			95165	Antigen therapy services
			95170	Antigen therapy services
			C8951	Intravenous infusion for therapy/diagnosis; each additional hour
			G0008	Admin influenza virus vac
			G0009	Admin pneumococcal vaccine
0438	S	$48.99	90773	Ther/proph/diag inj, ia
			96401	Chemo, anti-neopl, sq/im
			96402	Chemo hormon antineopl sq/im
			96405	Chemo intralesional, up to 7
			96406	Chemo intralesional over 7
			96423	Chemo ia infuse each addl hr
			96542	Chemotherapy injection
			C8952	Therapeutic, prophylactic or diagnostic injection; intravenous push
			C8955	Chemotherapy administration, intravenous; infusion technique, each additional hour
0439	S	$97.84	96420	Chemo, ia, push technique
			96440	Chemotherapy, intracavitary
			96445	Chemotherapy, intracavitary
			C8953	Chemotherapy administration, intravenous; push technique
0440	S	$112.94	96521	Refill/maint, portable pump
			96522	Refill/maint pump/resvr syst
			C8950	Intravenous infusion for therapy/diagnosis; up to 1 hour
0441	S	$154.86	96416	Chemo prolong infuse w/pump
			96422	Chemo ia infusion up to 1 hr
			96425	Chemotherapy, infusion method
			96450	Chemotherapy, into CNS
			C8954	Chemotherapy administration, intravenous; infusion technique, up to one hour
			C8957	Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable or implantable pump

We are accepting the APC Panel's recommendation for CY 2007 to use the bypass and "per unit" methodology as described in proposing a drug administration payment structure that includes a methodology to pay for

infusion services by the hour. Therefore, we are proposing to assign HCPCS codes for CY 2007 to six new drug administration APCs, as listed in Table 30–2, with payment rates based on median costs for the APCs from CY 2005 claims data as assigned in Table 30–1.

For CY 2007, the APC Panel also recommended that CMS reevaluate payment for IVIG administration, especially considering the resource intensity of IVIG infusions. We are accepting this APC Panel recommendation and believe that our proposed CY 2007 drug administration payment policy that would provide specific payment for each hour of infusion would provide more accurate and appropriate payment for lengthy infusions, including the administration of IVIG. IVIG administration in the outpatient hospital setting typically occurs over 3–6 hours, and under our proposal hospitals would receive separate payment for the first hour of infusion, along with payments for each of the additional 2–5 hours generally required for the IVIG infusion. Considerable hospital resources are used throughout the infusion period, including significant clinical staff time to monitor and adjust infusions based on patients' evolving conditions, so we believe separate payment for each additional hour is appropriate. With respect to separate payment for IVIG preadministration-related services, the APC Panel recommended that CMS maintain separate payment as long as it remains appropriate. For CY 2006 only, we created the temporary G-code G0332 (Preadministration-related services for intravenous infusion of immunoglobulin, per infusion encounter). We are accepting this APC Panel recommendation and have considered whether separate payment for IVIG preadministration-related services remains appropriate. Based upon our ongoing review of the IVIG marketplace and our CY 2007 proposed payment policies for items and services under the OPPS, we believe that separate payment for preadministration-related services specific to IVIG infusions would not be necessary in CY 2007 to ensure Medicare beneficiary access to IVIG.

Hospitals' cooperation during CY 2005 in reporting all drug administration services, whether or not separate payments were made for all such services, has allowed us to develop robust median costs for individual services so that we have sufficient information to propose this more specific APC payment structure for drug administration services for CY 2007. We believe that this proposed structure would make appropriate payments for the hospital resources required to provide drug administration services, as we have large numbers of claims for many specific drug administration services that reveal significant and differential costs. In particular, using this proposed APC structure should allow us to make more accurate payments to hospitals for complex and lengthy drug administration services furnished to Medicare beneficiaries for many medical conditions, while also providing accurate payments for individual services when they are provided alone.

IX. Proposed Hospital Coding and Payments for Visits

(If you choose to comment on issues in this section, please include the caption ''Visits'' at the beginning of your comment.)

A. Background

Currently, CMS instructs hospitals to use the CY 2006 CPT codes used by physicians and listed in Table 31 to report clinic and emergency department visits and critical care services on claims paid under the OPPS.

TABLE 31.—CY 2006 CPT CODES USED TO REPORT CLINIC AND EMERGENCY DEPARTMENT VISITS AND CRITICAL CARE SERVICES

CPT code	Descriptor
CPT Evaluation and Management Codes	
99201	Office or other outpatient visit for the evaluation and management of a new patient (Level 1).
99202	Office or other outpatient visit for the evaluation and management of a new patient (Level 2).
99203	Office or other outpatient visit for the evaluation and management of a new patient (Level 3).
99204	Office or other outpatient visit for the evaluation and management of a new patient (Level 4).
99205	Office or other outpatient visit for the evaluation and management of a new patient (Level 5).
99211	Office or other outpatient visit for the evaluation and management of an established patient (Level 1).
99212	Office or other outpatient visit for the evaluation and management of an established patient (Level 2).
99213	Office or other outpatient visit for the evaluation and management of an established patient (Level 3).
99214	Office or other outpatient visit for the evaluation and management of an established patient (Level 4).
99215	Office or other outpatient visit for the evaluation and management of an established patient (Level 5).
99241	Office consultation for a new or established patient (Level 1).
99242	Office consultation for a new or established patient (Level 2).
99243	Office consultation for a new or established patient (Level 3).
99244	Office consultation for a new or established patient (Level 4).
99245	Office consultation for a new or established patient (Level 5).
Emergency Department Visit CPT Codes	
99281	Emergency department visit for the evaluation and management of a patient (Level 1).
99282	Emergency department visit for the evaluation and management of a patient (Level 2).
99283	Emergency department visit for the evaluation and management of a patient (Level 3).
99284	Emergency department visit for the evaluation and management of a patient (Level 4).
99285	Emergency department visit for the evaluation and management of a patient (Level 5).
Critical Care Services CPT Codes	
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes.
99292	Each additional 30 minutes.

The majority of CPT code descriptors are applicable to both physician and facility resources associated with specific services. However, we have acknowledged from the beginning of the OPPS that we believe that CPT Evaluation and Management (E/M)

codes were defined to reflect the activities of physicians and do not describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients and critical care encounters. Presently, CPT indicates that office or other outpatient visit codes are used to report E/M services provided in the physician's office or in an outpatient or other ambulatory facility. For OPPS purposes, we refer to these as clinic visit codes. CPT also indicates that emergency department visit codes are used to report E/M services provided in the emergency department, defined as an ''organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.'' For OPPS purposes, we refer to these as emergency visit codes. CPT defines critical care services as the ''direct delivery by a physician(s) of medical care for a critically ill or critically injured patient.'' It also states that ''critical care is usually, but not always, given in a critical care area, such as * * * the emergency care facility.''

In the April 7, 2000 OPPS final rule (65 FR 18434), CMS instructed hospitals to report facility resources for clinic and emergency department visits using CPT E/M codes and to develop internal hospital guidelines to determine what level of visit to report for each patient. While awaiting the development of a national set of facility-specific codes and guidelines, we have advised that each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes.

During the January 2002 APC Panel meeting, the APC Panel recommended that CMS adopt the American College of Emergency Physicians (ACEP) intervention-based guidelines for facility coding of emergency department visits and develop guidelines for clinic visits that are modeled on the ACEP guidelines.

In the August 9, 2002 OPPS proposed rule, we proposed 10 new G-codes (Levels 1–5 Facility Emergency Services and Levels 1–5 Facility Clinic Services) for use in the OPPS to report hospital visits. We also asked for public comments regarding national guidelines for hospital coding of emergency and clinic visits. We discussed various types of models, reflecting on the advantages and disadvantages of each. We reviewed in detail the considerations around various discrete types of specific guidelines, including guidelines based on staff interventions, based upon staff time spent with the patient, based on resource intensity point scoring, and based on severity acuity point scoring related to patient complexity. We note below our analysis of the various models.

1. Guidelines Based on the Number or Type of Staff Interventions

Under this model, the level of service reported would be based on the number and/or type of interventions performed by nursing or ancillary staff. In the intervention model, baseline care (including registration, triage, initial nursing assessment, periodic vital signs as appropriate, simple discharge instructions, and exam room set up/clean up) and possibly a single minor intervention (for example, suture removal, rapid strep test, or visual acuity) would be reported by the lowest level of service. Higher levels of service would be reported as the number and/or complexity of staff interventions increased.

The most commonly recommended intervention-based guidelines were the facility-coding guidelines developed by the ACEP. The ACEP model uses examples of interventions to illustrate appropriate coding. Coders extrapolate from these examples to determine the correct level of service to report. The ACEP model uses the types of interventions rather than the number of interventions to determine the appropriate level of service. This means that the single most complex intervention determines the level of service, whether it was the only service provided (in addition to baseline care), whether other similarly complex interventions were also provided, or whether other interventions of less complexity were also provided. The intervention model is based on emergency department/clinic resource use, is simple, reflects the care given to the patient, and does not require additional facility documentation. However, we expressed concern that the intervention model may provide an incentive to provide unnecessary services and that it is susceptible to upcoding. In addition, it is not particularly focused on measuring and appropriately reporting a code reflecting total hospital resources used in a visit. Furthermore, the ACEP model requires extrapolation from a set of examples that could make it prone to variability across hospitals.

2. Guidelines Based on the Time Staff Spent With the Patient

Under this model, the level of service would be determined based on the amount of time hospital staff spent with a patient. The underlying assumption is that staff time spent with the patient is an appropriate proxy for total hospital resource consumption. In this model, if only baseline care (as described above) were provided, a Level 1 service would be reported. Higher levels of service would be reported based on increments of staff time beyond baseline care. For example, Level 2 could be reported for 11 to 20 minutes beyond baseline care, and Level 3 could be reported for 21 to 30 minutes beyond baseline care. This model is simple, correlates with total hospital resource use, and provides an objective standard for all hospitals to follow. However, we observed that this model would require additional, potentially burdensome documentation of staff time, could provide an incentive to work slowly or use less efficient personnel, and has the potential for upcoding and gaming.

3. Guidelines Based on a Point System Where a Certain Number of Points Are Assigned to Each Staff Intervention Based on the Time, Intensity, and Staff Type Required for the Intervention

In this model, points or weights are assigned to each facility service and/or intervention provided to a patient in the clinic or emergency department. The level of service is determined by the sum of the points for all services/interventions provided. Commenters to the August 9, 2002 proposed rule recommended various approaches to a point system, including point systems that assigned points based on the amount of staff time spent with the patient, the number of activities performed during the visit, and a combination of patient condition and activities performed. A point system would correlate with facility resource consumption and provide an objective standard. In addition, it is not as easily gamed because time-based interventions can be assigned a set number of points. However, we noted that a point system could present a significant burden for hospitals in terms of requiring additional, clinically unnecessary documentation. Point systems that are complex could require dedicated staff to monitor and maintain them.

4. Guidelines Based on Patient Complexity

Several variations were recommended in comments to the August 9, 2002 proposed rule, including assignment of

levels of service based on ICD–9–CM (International Classification of Diseases, Ninth Edition, Clinical Modification) diagnosis codes, based on complexity of medical decision making, or based on presenting complaint or medical problem. The premise for these guideline systems is that many emergency departments follow established protocols based on patients' presenting complaints and/or diagnoses. Therefore, assigning a level of service based on patient diagnosis should correlate with facility resource consumption. These systems may require the use of a coding ''grid,'' which lists more than 100 examples of patient conditions and diagnoses and assigns a level of service to each example. When the patient presents with a condition that does not appear on the grid, the coder must extrapolate from the grid to the individual patient. We expressed concern that these systems are extremely complex, demand significant interpretive work on the part of the coder (who may not have clinical experience), and are subject to variability across hospitals. While no clinically unnecessary documentation would be required because the system is based on diagnoses that are already reported on claims, there is a significant potential for upcoding and gaming.

In the August 9, 2002 OPPS proposed rule, we also stated that we were concerned about counting separately paid services (for example, intravenous infusions, x-rays, electrocardiograms, and lab tests) as ''interventions'' or including their associated ''staff time'' in determining the level of service. We believed that the level of service should be determined by resource consumption that is not otherwise captured in payments for other separately payable services. We are now reconsidering this perspective and will discuss this further in section IX.D. of the preamble of this proposed rule.

In the November 1, 2002 OPPS final rule, we specified that we would not create new codes to replace existing CPT E/M codes for reporting hospital visits until national guidelines have been developed, in response to commenters who were concerned about implementing code definitions without national guidelines. We noted that an independent panel of experts would be an appropriate forum to develop codes and guidelines that are simple to understand and implement, and that are compliant with the HIPAA requirements. We explained that organizations such as the American Hospital Associations (AHA) and the American Health Information Management Association (AHIMA) had such expertise and would be capable of creating hospital visit guidelines and providing ongoing education of providers. We also articulated a set of principles that any national guidelines for facility visit coding should satisfy, including that coding guidelines should be based on facility resources, should be clear to facilitate accurate payments and be usable for compliance purposes and audits, should meet the HIPAA requirements, should only require documentation that is clinically necessary for patient care, and should not facilitate upcoding or gaming. We stated that the distribution of codes should result in a normal curve. We concluded that we believed the most appropriate forum for development of code definitions and guidelines was an independent expert panel that would makes recommendations to CMS.

The AHA and AHIMA originally supported the ACEP model for emergency visit coding, but we expressed concern that the ACEP guidelines allowed counting of separately payable services in determining a service level, which could result in the double counting of hospital resources in establishing visit payment rates and payment rates for those separately payable services. Subsequently, on their own initiative, the AHA and AHIMA formed an independent expert panel, the Hospital Evaluation and Management Coding Panel, comprised of members with coding, health information management, documentation, billing, nursing, finance, auditing, and medical experience. This panel included representatives from the AHA, AHIMA, ACEP, Emergency Nurses Association, and American Organization of Nurse Executives. CMS and AMA representatives observed the meetings. On June 24, 2003, the AHA and AHIMA submitted their recommended guidelines, hereafter referred to as the AHA/AHIMA guidelines, for reporting three levels of hospital clinic and emergency visits and a single level of critical care services to CMS, with the hope that CMS would publish the guidelines in the CY 2004 proposed rule. The AHA and AHIMA acknowledged that ''continued refinement will be required as in all coding systems. The Panel * * * looks forward to working with CMS to incorporate any recommendations raised during the public comment period'' (AHA/AHIMA guidelines report, page 9). The AHA and AHIMA indicated that the guidelines were field-tested several times by panel members at different stages of their development. The guidelines are based on an intervention model, where the levels are determined by the numbers and types of interventions performed by nursing or ancillary hospital staff. Higher levels of services are reported as the number and/or complexity of staff interventions increase.

Although we did not publish the guidelines, the AHA and AHIMA released the guidelines through their Web sites. Consequently, we received numerous comments from providers and associations, some in favor and some opposed to the guidelines. We undertook a critical review of the recommendations from the AHA and AHIMA and made some modifications to the guidelines based on comments we received from outside hospitals and associations on the AHA/AHIMA guidelines, clinical review, and changing payment policies in the OPPS regarding some separately payable services.

In an attempt to validate the modified AHA/AHIMA guidelines and examine the distribution of services that would result from their application to hospital clinic and emergency visits paid under the OPPS, we contracted a study that began in September 2004 and concluded in September 2005 to retrospectively code, under the modified AHA/AHIMA guidelines, hospital visits by reviewing hospital visit medical chart documentation gathered through the Comprehensive Error Rate Testing (CERT) work. While a review of documentation and assignment of visit levels based on the modified AHA/AHIMA guidelines to 12,500 clinic and emergency visits was initially planned, the study was terminated after a pilot review of only 750 visits. The contractor identified a number of elements in the guidelines that were difficult for coders to interpret, poorly defined, nonspecific, or regularly unavailable in the medical records. The contractor's coders were unable to determine any level for about 25 percent of the clinic cases and about 20 percent of the emergency cases reviewed. The only agreement observed between the levels reported on the claims and levels according to the modified AHA/AHIMA guidelines was the classification of Level 1 services, where the review supported the level on the claims 54–70 percent of the time. In addition, the vast majority of the clinic and emergency visits reviewed were assigned to Level 1 during the review. Based on these findings, we believed that it was not necessary to review additional records after the initial sample. The contractor advised that multiple terms in the guidelines required clearer definition and believed

that more examples would be helpful. Although we believe that all of the visit documentation for each case was available for the contractor's review, we were unable to determine definitively that this was the case. Thus, there is some possibility that the contractor's assignments would have differed if additional documentation from the medical records was available for the visits. In summary, while testing of the modified AHA/AHIMA guidelines was helpful in illuminating areas of the guidelines that would benefit from refinement, we were unable to draw conclusions about the relationship between the distribution of current hospital reporting of visits using CPT E/M codes that are assigned according to each hospital's internal guidelines and the distribution of coding under the AHA/AHIMA guidelines, nor were we able to demonstrate a normal distribution of visit levels under the modified AHA/AHIMA guidelines.

B. CY 2007 Proposed Coding

As discussed above, the majority of all CPT code descriptors are applicable to both physician and facility resources associated with specific services. However, we believe that CPT E/M codes were defined to reflect the activities of physicians and do not describe well the range and mix of services provided by hospitals during visits of clinic and emergency department patients and critical care encounters. While awaiting the development of a national set of facility-specific codes and guidelines, we have advised that each hospital's internal guidelines should follow the intent of the CPT code descriptors, in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the codes.

In the November 1, 2002 OPPS final rule, we specified that we would not create new codes to replace existing CPT E/M codes for reporting hospital visits until national guidelines have been developed, in response to commenters who were concerned about implementing code definitions without national guidelines. While we do not yet have a formal set of guidelines that we believe may be appropriately applied nationally to report different levels of hospital clinic and emergency department visit and to report critical care services, we have made significant progress in developing potential guidelines and, therefore, are proposing for CY 2007 the establishment of HCPCS codes to describe hospital clinic and emergency department visits and critical care services. Prior to our implementation of national guidelines for the new hospital visit HCPCS codes, we are proposing that hospitals may continue to use their existing internal guidelines to determine the visit levels to be reported with these codes. We anticipate that many providers would choose to use their existing guidelines for reporting visits with CPT codes. We do not expect a substantial workload for a provider that chooses to adjust its guidelines to reflect our proposed policies.

We acknowledge that it can be burdensome for providers to bill G-codes rather than CPT codes. In this case, because current CPT E/M codes do not describe hospital visit resources, we have no alternative other than to create new G-codes. CPT has not yet created clinic and emergency department visit and critical care services codes that describe hospital resource utilization. It is important to note that G-codes may be recognized by other payers.

1. Clinic Visits

For clinic visits, we are proposing five new codes, to replace hospitals' reporting of the CPT clinic visit E/M codes for new and established patients and consultations listed in Table 31. Providers have been reporting five levels of CPT codes through CY 2006, and we believe that it should be fairly easy to crosswalk current internal hospital guidelines to these five proposed new codes. Commenters to prior rules have stated that the hospital resources used for new and established patients to provide a specific level of service are very similar, and that it is unnecessary and burdensome from a coding perspective to distinguish between the two types of visits. The new codes are proposed in Table 32 below.

TABLE 32.—PROPOSED CY 2007 HCPCS CODES TO BE USED TO REPORT CLINIC VISITS

HCPCS code	Short descriptor	Long descriptor
Gxxx1	Level 1 hosp clinic visit	Level 1 hospital clinic visit.
Gxxx2	Level 2 hosp clinic visit	Level 2 hospital clinic visit.
Gxxx3	Level 3 hosp clinic visit	Level 3 hospital clinic visit.
Gxxx4	Level 4 hosp clinic visit	Level 4 hospital clinic visit.
Gxxx5	Level 5 hosp clinic visit	Level 5 hospital clinic visit.

2. Emergency Department Visits

As described above, CPT defines an emergency department as ''an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.'' Under the OPPS, we have restricted the billing of emergency department CPT codes to services furnished at facilities that meet this CPT definition. Facilities open less than 24 hours a day should not use the emergency department codes.

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Act impose specific obligations on Medicare-participating hospitals and critical access hospitals that offer emergency services. These obligations concern individuals who come to a hospital's dedicated emergency department (DED) and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether or not they are beneficiaries of any program under the Act. Section 1867(h) of the Act specifically prohibits a delay in providing required screening or stabilization services in order to inquire about the individual's payment method or insurance status. Section 1867(d) of the Act provides for the imposition of civil monetary penalties on hospitals and physicians responsible for failing to meet the provisions listed above. These provisions, taken together, are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA). EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 Pub. L. 99–272 (COBRA).

Section 489.24 of the EMTALA regulations defines ''dedicated emergency department'' as any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is

held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

We believe that every emergency department that meets the CPT definition of emergency department also qualifies as a dedicated emergency department under EMTALA. However, we are aware that there are some departments or facilities of hospitals that meet the definition of a DED under the EMTALA regulations but that do not meet the more restrictive CPT definition of an emergency department. For example, a hospital department or facility that meets the definition of a DED may not be available 24 hours a day, 7 days a week. Nevertheless, hospitals with such departments or facilities incur EMTALA obligations with respect to an individual who presents to the department and requests, or has requested on his or her behalf, examination or treatment for an emergency medical condition. However, because they do not meet the CPT requirements for reporting emergency visit E/M codes, these facilities must bill clinic visit codes for the services they furnish. We have no way to distinguish in our hospital claims data the costs of visits provided in DEDs that do not meet the CPT definition of emergency department from the costs of clinic visits.

Some hospitals have requested that they be permitted to bill emergency visit codes under the OPPS for services furnished in a facility that meets CPT's definition for reporting emergency visit E/M codes, except that they are not available 24 hours a day. These hospitals believe that their resource costs are more similar to those of emergency departments that meet the CPT definition than they are to the resource costs of clinics. Representatives of such facilities have argued that emergency department visit payments are more appropriate, on the grounds that their facilities treat patients with emergency conditions whose costs exceed the resources reflected in the clinic visit APC payments, even though these emergency departments are not available 24 hours per day. In addition, these hospital representatives indicated that their facilities have EMTALA obligations and should, therefore, be able to receive emergency visit payments. While these emergency departments may provide a broader range and intensity of hospital services and require significant resources to assure their availability and capabilities in comparison with typical hospital outpatient clinics, the fact that they do not operate with all capabilities full-time suggests that hospital resources associated with visits to emergency departments or facilities available less than 24 hours a day may not be as great as the resources associated with emergency departments or facilities that are available 24 hours a day and that fully meet the CPT definition.

To determine whether visits to emergency departments or facilities (referred to as Type B emergency departments) that incur EMTALA obligations but do not meet more prescriptive expectations that are consistent with the CPT definition of an emergency department (referred to as Type A emergency departments) have different resource costs than visits to either clinics or Type A emergency departments, for CY 2007 we are proposing a set of five G-codes for use by all entities that meet the definition of a DED under the EMTALA regulations in § 489.24 but that are not Type A emergency departments, as described in Table 33 below. These codes will be called ''Type B emergency visit codes.''

TABLE 33.—PROPOSED CY 2007 HCPCS CODES TO BE USED TO REPORT EMERGENCY VISITS PROVIDED IN TYPE B EMERGENCY DEPARTMENTS

HCPCS code	Short descriptor	Long descriptor
Gzzz1	Lev 1 hosp type B ED visit.	Level 1 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
Gzzz2	Lev 2 hosp type B ED visit.	Level 2 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).

TABLE 33.—PROPOSED CY 2007 HCPCS CODES TO BE USED TO REPORT EMERGENCY VISITS PROVIDED IN TYPE B EMERGENCY DEPARTMENTS—Continued

HCPCS code	Short descriptor	Long descriptor
Gzzz3	Lev 3 hosp type B ED visit.	Level 3 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
Gzzz4	Lev 4 hosp type B ED visit.	Level 4 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
Gzzz5	Lev 5 hosp type B ED visit.	Level 5 hospital emergency department visit provided in a Type B emergency department. (The ED must meet at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).

For CY 2007, we also are proposing to create five G-codes to be reported by the subset of provider-based emergency departments or facilities of the hospital, called Type A emergency departments, that are available to provide services 24 hours a day, 7 days per week and meet one or both of the following requirements related to the EMTALA definition of DED, specifically: (1) It is licensed by the State in which it is located under the applicable State law as an emergency room or emergency department; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. These codes will be called ''Type A emergency visit codes'' and would replace hospitals' current reporting of the CPT emergency department visit E/M codes listed in Table 33. Our intention is to allow hospital-based emergency departments or facilities that are currently appropriately reporting CPT emergency department visit E/M codes to bill these new Type A emergency visit codes. We believe that this proposed definition of Type A emergency departments will neither narrow nor broaden the group of emergency departments or facilities that may bill the Type A emergency visit codes in comparison with those that are currently correctly billing CPT emergency department visit E/M codes. Rather, we are refining and clarifying the definition for use in the hospital context. We believe that because the concepts employed in the definition of a DED for EMTALA purposes are already familiar to hospitals, it is appropriate to employ those concepts, rather than the concepts employed in the CPT definition of emergency department, for purposes of defining these new G-codes. As we have previously noted, the CPT codes were defined to reflect the activities of physicians and do not always describe well the range and mix of services provided by hospitals during visits of emergency department patients. We believe that these new codes that we are proposing for reporting emergency visits to Type A emergency departments are more specific to the hospital context. For example, one feature that distinguishes Type A hospital emergency departments from other departments of the hospital is that Type A emergency departments do not generally provide scheduled care, but rather regularly operate to provide immediately available unscheduled services.

The new codes that we are proposing for CY 2007 are listed in Table 34 below.

TABLE 34.—PROPOSED CY 2007 HCPCS CODES TO BE USED TO REPORT EMERGENCY VISITS PROVIDED IN TYPE A EMERGENCY DEPARTMENTS

HCPCS code	Short descriptor	Long descriptor
Gyyy1	Lev 1 hosp type A ED visit.	Level 1 hospital emergency visit provided in a Type A hospital-based facility or department. (The facility or department must be open 24 hours a day, 7 days a week and meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
Gyyy2	Lev 2 hosp type A ED visit.	Level 2 hospital emergency visit provided in a Type A hospital-based facility or department. (The facility or department must be open 24 hours a day, 7 days a week and meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
Gyyy3	Lev 3 hosp type A ED visit.	Level 3 hospital emergency visit provided in a Type A hospital-based facility or department. (The facility or department must be open 24 hours a day, 7 days a week and meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
Gyyy4	Lev 4 hosp type A ED visit.	Level 4 hospital emergency visit provided in a Type A hospital-based facility or department. (The facility or department must be open 24 hours a day, 7 days a week and meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; or (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment).
Gyyy5	Lev 5 hosp type A ED visit.	Level 5 hospital emergency visit provided in a Type A hospital-based facility or department. (The facility or department must be open 24 hours a day, 7 days a week and meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department; 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).

3. Critical Care Services

For critical care services, we are proposing two new codes, to replace hospitals' reporting of the CPT E/M critical care codes listed in Table 31. Providers have been reporting two CPT codes through CY 2006, and we believe that it should be fairly easy to crosswalk current internal hospital guidelines to these two new proposed codes. The proposed new codes are listed in Table 35 below.

TABLE 35.—PROPOSED CY 2007 HCPCS CODES TO BE USED TO REPORT CRITICAL CARE SERVICES

HCPCS code	Short descriptor	Long descriptor
Gccc1	Hosp critical care, 30–74 min	Hospital critical care services, first 30–74 minutes.
Gccc2	Hosp critical care, add 30 min	Hospital critical care services, each additional 30 minutes.

C. CY 2007 Proposed Payment Policy

Since the implementation of the OPPS, outpatient visits provided by hospitals have been paid at three payment levels for both clinic and emergency department visits, even though hospitals have been reporting five resource-based coding levels of clinic and emergency department visits using CPT E/M codes. Critical care services have been paid at one level, with separate payment for the first 30 to 74 minutes of care and bundling of payment for all additional 30 minute increments of critical care services into payment for the first 30–74 minutes. If the critical care service is less than 30 minutes in duration, then it is to be billed as either a clinic visit or an emergency visit CPT code. Because the three payment rates for clinic and emergency department visits are based on five levels of CPT codes as listed in Table 31, in general the two lowest levels of CPT codes (1 and 2) are assigned to the low-level visit APCs and the two highest levels of CPT codes (4 and 5) are assigned to the high-level visit APCs, with the single middle CPT level CPT code (3) assigned to the mid-level visit APCs. Hospital claims data indicate that the cost of providing a visit of the same level is generally significantly higher for emergency visits in comparison with clinic visits, with the differential increasing at higher levels of services.

Based upon CY 2005 claims data processed through December 31, 2005, the median costs of clinic visit, emergency visit, and critical care APCs as configured for CY 2006 are listed below.

TABLE 36.—MEDIAN COSTS OF CLINIC AND EMERGENCY VISIT AND CRITICAL CARE APCS AS CONFIGURED FOR CY 2006

APC title	APC median	Levels of CPT codes assigned to APC
Clinic Visits		
Low Level Clinic Visits	$53.94	Level 1 Clinic Visit, Level 2 Clinic Visit.
Mid Level Clinic Visits	63.73	Level 3 Clinic Visit.
High Level Clinic Visits	91.27	Level 4 Clinic Visit, Level 5 Clinic Visit.
Emergency Department Visits		
Low Level Emergency Visits	76.43	Level 1 ED Visit, Level 2 ED Visit.
Mid Level Emergency Visits	133.98	Level 3 ED Visit.
High Level Emergency Visits	237.17	Level 4 ED Visit, Level 5 ED Visit.
Critical Care Services		
Critical Care	495.16	Critical care, first hour.

Historical hospitals claims data, however, have generally reflected significantly different median costs for the two levels of services assigned to the low and high level visit APCs. While the median costs of these services do not violate the 2 times rule within their assigned APCs, this may not be the most accurate method of payment for these very common hospital levels of visits which clearly demonstrate differential hospital resources. In particular, because of the relatively low volume of the highest levels of services in the clinic and emergency department, our payment rates may be especially low. Therefore, we are proposing five payment levels for clinic and emergency visits and one payment level for critical care services.

As discussed in the previous section, we are proposing to create 17 new G-codes to replace the CPT E/M codes that hospitals are currently billing to report visits and critical care services. To determine appropriate payment rates for the new G-codes, we are proposing to map the data from the CY 2005 CPT E/M codes and other HCPCS codes currently assigned to the clinic visit APCs to 11 new APCs, 5 for clinic visits, 5 for emergency visits, and 1 for critical care services as shown in Table 37 to develop median costs for these APCs. We mapped the CPT E/M codes and other HCPCS codes to the new APCs based on median costs and clinical considerations.

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Table 37.--Proposed Assignment of Claims Data from CY 2005 CPT E/M Codes and Other HCPCS Codes to New Visit APCs for CY 2007

Proposed CY 2007 APC Title	Proposed CY 2007 APC	HCPCS Code	Short Descriptor
Level 1 Hospital Clinic Visits	0604	92012	Eye exam established pat
		99201	Office/outpatient visit, new (Level 1)
		99211	Office/outpatient visit, est (Level 1)
		G0101	CA screen; pelvic/breast exam
		G0245	Initial foot exam pt lops
		G0248	Demonstrate use home inr mon
		G0249	Provide test material, equipm
		G0264	Assmt otr CHF, CP, asthma
Level 2 Hospital Clinic Visits	0605	92002	Eye exam, new patient
		92014	Eye exam and treatment
		99202	Office/outpatient visit, new (Level 2)
		99212	Office/outpatient visit, est (Level 2)
		99213	Office/outpatient visit, est (Level 3)
		99241	Office consultation (Level 1)
		99242	Office Consultation (Level 2)
		99271	Confirmatory consultation (Level 1)
		99272	Confirmatory consultation (Level 2)
		99431	Initial care, normal newborn
		G0246	Folloup eval of foot pt lop
		G0344	Initial preventive exam
Level 3 Hospital Clinic Visits	0606	92004	Eye exam, new patient
		99203	Office/outpatient visit, new (Level 3)
		99214	Office/outpatient visit, est (Level 4)
		99243	Office consultation (Level 3)
Level 4 Hospital Clinic Visits	0607	99204	Office/outpatient visit, new (Level 4)
		99215	Office/outpatient visit, est (Level 5)
		99244	Office consultation (Level 4)
		99273	Confirmatory consultation (Level 3)
		99274	Confirmatory consultation (Level 4)
Level 5 Hospital Clinic Visits	0608	99205	Office/outpatient visit, new (Level 5)
		99245	Office consultation (Level 5)
		99275	Confirmatory consultation (Level 5)
		G0175	OPPS service, sched team conf
Level 1 Type A Emergency Visits	0609	99281	Emergency department visit
Level 2 Type A Emergency Visits	0613	99282	Emergency depepartment visit
Level 3 Type A Emergency Visits	0614	99283	Emergency department visit
Level 4 Type A Emergency Visits	0615	99284	Emergency department visit
Level 5 Type A Emergency Visits	0616	99285	Emergency department visit
Critical Care	0617	99291	Critical care, first hour

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In the case of the CPT E/M codes for emergency visits, the assignment of data from a single visit code to the new Type A Emergency Visit APC of the same level was straightforward. Similarly, the assignment of data from the only separately payable critical care CPT code to the new APC for critical care services was clear-cut. However, in some cases of the data for CPT clinic visit E/M codes, we assigned a code to

an appropriate clinic visit APC level based upon resource and clinical homogeneity considerations, and that APC assignment did not correspond to the visit level described by the code. For example, CPT 99213 is a level 3 clinic visit code for an established patient, which would seem to logically map to the Level 3 Clinic Visit APC. However, because CPT 99213 has a median cost of $63.04, it maps more appropriately to the Level 2 Clinic Visit APC, which has an overall median cost of $62.12. In general, CPT codes for established patient visits had lower median costs than new patient visit or consultation codes of the same E/M level, and that variability is reflected in their respective proposed APC data assignments for CY 2007. We believe that in CY 2007, when hospitals utilize their own internal guidelines to report clinic visits, without codes that differentiate among new, established, or consultation visits, they will report G-code levels that reflect their resources used. We expect that payments provided for G-codes of each level, based upon the CY 2005 claims data assignments as listed in Table 38, would provide appropriate resource-based payments for visits reported at each level.

After the CY 2005 CPT E/M codes and other HCPCS codes were mapped to an appropriate new APC as shown in Table 38, the next step required was to assign an APC to each new G-code for which no data were available. We assigned these 16 new separately payable G-codes to an appropriate APC level based on the code level alone as shown in Table 38. For example, both the Level 1 Hospital Clinic Visit and Level 1 Hospital Type B ED visit codes are mapped to the Level 1 Hospital Clinic Visit APC, 0604. Similarly, the Level 1 Hospital Type A ED visit code is mapped to the Level 1 Type A Emergency Visit APC, 0609. We expect that this configuration would provide appropriate resource-based payments for visits reported at each level. We are proposing to assign status indicator ''B'' to the CPT E/M codes for CY 2007, with no APC assignment, because we are proposing new G-codes for the OPPS for CY 2007, as delineated in Table 38. Table 38 also removes codes that were deleted by CPT for CY 2007, and only includes codes that would be effective under the OPPS for CY 2007.

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Table 38.--CY 2007 Proposed Clinic Visit, Emergency Visit, and Critical Care Services APC Assignments

CPT/HCPCS Code for Reporting in CY 2007	Description	Proposed CY 2007 APC Title	Proposed CY 2007 APC	APC Status Indicator	Proposed CY 2007 APC Median
Gxxx1	Level 1 hosp clinic visit	Level 1 Hospital Clinic Visits	0604	V	$49.93
Gzzz1	Lev 1 hosp general ED visit				
92012	Eye exam established pat				
G0101	CA screen; pelvic/breast exam				
G0245	Initial foot exam pt lops				
G0248	Demonstrate use home inr mon				
G0249	Provide test material, equipm				
G0264	Assmt otr CHF, CP, asthma				
Gxxx2	Level 2 hosp clinic visit	Level 2 Hospital Clinic Visits	0605	V	$62.12
Gzzz2	Lev 2 hosp general ED visit				
92002	Eye exam, new patient				
92014	Eye exam and treatment				
G0246	Folloup eval of foot pt lop				
G0344	Initial preventive exam				
Gxxx3	Level 3 hosp clinic visit	Level 3 Hospital Clinic Visits	0606	V	$83.67
Gzzz3	Lev 3 hosp general ED visit				
92004	Eye exam, new patient				
Gxxx4	Level 4 hosp clinic visit	Level 4 Hospital Clinic Visits	0607	V	$105.50
Gzzz4	Lev 4 hosp general ED visit				
Gxxx5	Level 5 hosp clinic visit	Level 5 Hospital Clinic Visits	0608	V	$130.38
Gzzz5	Lev 5 hosp general ED visit				
G0175	OPPS service, sched team conf				
Gyyy1	Lev 1 hosp special ED visit	Level 1 Special Emergency Visits	0609	V	$51.41
Gyyy2	Lev 2 hosp special ED visit	Level 2 Special Emergency Visits	0613	V	$84.79
Gyyy3	Lev 3 hosp special ED visit	Level 3 Special Emergency Visits	0614	V	$133.98
Gyyy4	Lev 4 hosp special ED visit	Level 4 Special Emergency Visits	0615	V	$214.88
Gyyy5	Lev 5 hosp special ED visit	Level 5 Special Emergency Visits	0616	V	$332.14
Gccc1	Critical care, first hour	Critical Care	0617	S	$495.16

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We are proposing to map the five new clinic visit G-codes to the five new Clinic Visit APCs, 0604, 0605, 0606, 0607, and 0608. We are proposing to assign the five new Type A emergency visit codes for services provided in a Type A emergency department to the five new Type A Emergency Visit APCs, 0609, 0613, 0614, 0615, and 0616. For CY 2007, we are proposing to assign the five new Type B emergency visit codes for services provided in a Type B emergency department to the five new Clinic Visit APCs, 0604, 0605, 0606, 0607, and 0608.

This payment policy for Type B emergency visits is similar to our current policy which requires services furnished in emergency departments that have an EMTALA obligation but do not meet the CPT definition of emergency department to be reported using CPT clinic visit E/M codes, resulting in payments based upon clinic visit APCs. As mentioned above, CPT requires an emergency department to be open 24 hours per day in order for it to be eligible to bill emergency department E/M codes. While maintaining the same payment policy for Type B emergency department visits in CY 2007, the reporting of specific G-codes for emergency visits provided in Type B emergency departments will permit us to specifically collect and analyze the hospital resource costs of visits to these facilities in order to determine in the future whether a proposal of an alternative payment policy may be warranted. This approach to more refined data collection is similar to our approach to drug administration services under the OPPS over the past several years. We collected hospital claims data for specific detailed services using CPT and HCPCS codes for CYs 2005 and 2006, while making payments based on claims data available to us for the less specific HCPCS codes billed by hospitals prior to CY 2005. We recognize that reporting specific drug administration services for which hospitals received no separate or

additional payments created some additional administrative burden on hospitals for a period of time, but the resource information collected through the claims submissions has been critical to the development of our proposal of more refined drug administration payment policies. The hospital claims data based upon the CY 2005 drug administration coding structure now form the foundation of our CY 2007 proposal for drug administration services as described in section VIII.C. of the preamble to this proposed rule.

Although we believe that our proposed payment policy for CY 2007 for Type B emergency department visits is consistent with our past policy regarding visits to emergency departments that do not meet the CPT definition of an emergency department, we are interested in public comments regarding this policy. The OPPS rulemaking cycle for CY 2009 will be the first year that we will have cost data for these new Type B emergency department HCPCS codes available for analysis. In the interim, we are particularly concerned with ensuring that necessary emergency department services are available to rural Medicare beneficiaries. We recognize that rural emergency departments may be disproportionately likely to offer essential emergency department services less than 24 hours per day, 7 days a week because of the limited demand for those services and the high costs and inefficiencies associated with providing full emergency department availability during times when few patients are present for emergency care. We believe that our OPPS payment policies for Type A and Type B emergency visits should support the ability of hospitals to provide their communities with essential and appropriate emergency department services efficiently and effectively. We also believe that the payment policies should present no payment incentive for hospitals to provide necessary emergency services less than 24 hours per day, 7 days per week, which could result in limited access to emergency services for Medicare beneficiaries, thereby leading to adverse effects on their health.

We are proposing to map code Gccc1, the new proposed hospital critical care services code for the first 30–74 minutes of care, to the proposed new Critical Care APC 0617. We are proposing to assign status indicator ''N'' to proposed HCPCS code Gccc2, to indicate that the code is packaged, as the predecessor code to Gccc2 was also packaged.

D. CY 2007 Proposed Treatment of Guidelines

1. Background

As described in section IX.A. of the preamble of this proposed rule, since April 7, 2000 we have instructed hospitals to report facility resources for clinic and emergency department outpatient hospital visits using the CPT E/M codes and to develop internal hospital guidelines for reporting the appropriate visit level. In the CY 2003 OPPS final rule with comment period, we noted that an independent panel of experts would be an appropriate forum to develop codes and guidelines. In that final rule with comment period, we also articulated a set of principles that any national guidelines for facility visit coding should satisfy, including that coding guidelines should be based on facility resources, should be clear to facilitate accurate payments and be usable for compliance purposes and audits, should meet the HIPAA requirements, should only require documentation that is clinically necessary for patient care, and should not facilitate upcoding or gaming. We stated that the distribution of codes should result in a normal curve.

Subsequently, as described above, the AHA and AHIMA formed an independent expert panel, the Hospital Evaluation and Management Coding Panel, and submitted the AHA/AHIMA guidelines for reporting three levels of hospital clinic and emergency visits and a single level of critical care services to CMS. The guidelines are based on an intervention model, where the levels are determined by the numbers and types of interventions performed by nursing or ancillary hospital staff. We undertook a critical review of the recommendations and made some modifications to the guidelines based on comments we received from outside hospitals and associations, clinical review, and changing payment policies in the OPPS regarding some separately payable services. In addition, as previously stated, we contracted a study to retrospectively code, under the modified AHA/AHIMA guidelines, hospital visits by reviewing hospital visit medical chart documentation gathered through CERT work. In summary, while the testing of the modified AHA/AHIMA guidelines was helpful in illuminating areas of the guidelines that would benefit from refinement, we were unable to draw conclusions about the relationship between the distribution of current hospital reporting of visits using CPT E/M codes that are assigned according to each hospital's internal guidelines and the distribution of code levels under the AHA/AHIMA guidelines, nor were we able to demonstrate a normal distribution of visit levels under the modified AHA/AHIMA guidelines.

Despite the inconclusive findings from the validation study, after reviewing the AHA/AHIMA guidelines, as well as approximately a dozen other guidelines for outpatient visits submitted by various hospitals and hospital associations, we believe that the AHA/AHIMA guidelines are the most appropriate and well-developed guidelines for use in the OPPS of which we are aware. Our particular interest in these guidelines is based upon the broad-based input into their development, the need for CMS to move definitively to promulgate national outpatient hospital visit coding guidelines in the near future, and full consideration of the characteristics of alternative types of guidelines. We also think that hospitals will react favorably to guidelines developed and supported by the AHA and AHIMA, national organizations that have great interest in hospital coding and payment issues and possess significant medical, technical and practical expertise due to their broad membership, which includes hospitals and health information management professionals. Anecdotally, we have been told that a number of hospitals are successfully utilizing the AHA/AHIMA guidelines to report levels of hospital visits. However, other organizations have expressed concern that the AHA/AHIMA guidelines may result in a significant redistribution of hospital visits to higher levels, reducing the ability of the OPPS to discriminate among the hospital resources required for various different levels of visits. We, too, remain concerned about the potential redistributive effect on OPPS payments for other services or among levels of hospital visits when national guidelines for outpatient visit coding are adopted. We recognize that there may be difficulty crosswalking historical hospital claims data from current CPT E/M codes reported based on individual internal hospital guidelines to payments for any new coding system developed, in order to provide appropriate payment levels for hospital visits reported based on national guidelines in the future.

There are several types of problems with the AHA/AHIMA guidelines that have been identified based upon extensive staff review and contractor use of the guidelines during the validation study. We believe the AHA/AHIMA guidelines require short-term refinement prior to their full adoption by the OPPS, as well as continued refinement over time after their

implementation. Our modified version of the AHA/AHIMA guidelines provides some possibilities for addressing certain issues. Our eight general areas of concern regarding the AHA/AHIMA model are listed below. In addition, we have posted to the CMS Web site both the original AHA/AHIMA guidelines and our modified draft version, and we are seeking public input before we adopt national guidelines. We continue to commit that we will provide a minimum of 6–12 months notice to hospitals prior to implementation of national guidelines to provide sufficient time for providers to make the necessary systems changes and educate their staff.

2. Outstanding Concerns With the AHA/AHIMA Guidelines

a. Three Versus Five Levels of Codes

The AHA/AHIMA guidelines describe three levels of codes for clinic and emergency visits, rather than the five levels of codes that we are proposing for clinic and Type A and Type B emergency visits. It would be impossible to pay at five levels using these guidelines, unless the guidelines were revised. As discussed above, our claims data indicate that five payment levels are justified for both clinic and Type A emergency visits, and, therefore, we are proposing five levels of G-codes so that providers may code at five visit levels and receive payments at five levels as well. In fact, the materials explaining the AHA/AHIMA guidelines state that one of the reasons that the model includes only three coding levels is because CMS only paid at three payment levels. We are now proposing to pay at five payment levels, and if our proposed CY 2007 payment policy is finalized, the AHA/AHIMA guidelines may need to be revised to reflect five visit levels.

b. Lack of Clarity for Some Interventions

Some interventions are vague, unclear, or nonspecific, without sufficient examples of documentation in the medical record that may support those interventions. For instance, it is unclear what documentation for the intervention stated as ''Patient registration, room set up, patient use of room, room cleaning'' and assigned in the AHA/AHIMA guidelines to a low-level clinic visit would be necessary to support all aspects of that intervention. In another case, the intervention ''Frequent monitoring/assessment as evidenced by two sets of vital sign measurements or assessments'' that is attributable to a mid-level emergency visit in the guidelines explains that this may include assessment of cardiovascular, pulmonary, or neurological status. However, it is unclear exactly what coders should look for in the medical record to support this intervention and whether narrative hospital staff descriptions of patient status would be considered to be assessments. These examples, and others, were identified by the contractor engaged in medical chart reviews as part of the guidelines validation study. The AHA/AHIMA guidelines may benefit from revisions to clarify some interventions and/or provide additional examples based upon questions that arose during field testing of the guidelines or that are raised by hospitals reviewing the AHA/AHIMA guidelines and the modified version posted on our Web site.

c. Treatment of Separately Payable Services

CMS and the APC Panel stated that separately payable services should be excluded from the guidelines because of their concern over the potential for double payment for hospital resources attributed to visit services when those resources were actually used to provide the separately payable services. Consistent with this policy, at the time of their development the AHA/AHIMA guidelines excluded all services separately payable under the OPPS from the list of interventions. For policy consistency, in our modified draft version of the guidelines, we removed interventions that have now become separately payable under the OPPS through CY 2006, such as bladder catheterizations and some wound care services. However, upon further reflection as we move forward to implement national guidelines, we are open to reconsidering whether the inclusion of some separately payable services in guidelines to determine visit levels could serve as a proxy for the resources that the patient will consume and that should be attributable to the hospital visit, not the separately payable services. In such cases, consideration of separately payable services in reporting visit levels may not result in double payment for components of those separately payable services. There may be hospital resources used in visits that are not captured in the AHA/AHIMA guidelines' limited number of interventions that are not separately payable. We believe that, in general, a patient with high medical acuity will consume more hospital resources in the visit than a patient with moderate acuity. However, when separately payable interventions are removed from the model, it may be difficult for the limited interventions remaining in the guidelines for each visit level to capture the acuity level of the patient. In addition, the list of HCPCS codes that are packaged can change annually. For example, in the CY 2006 OPPS, bladder catheterization services, which had been packaged in prior years, were first made separately payable. If the guidelines strictly excluded all separately payable services, then the guidelines could also change from year to year, possibly requiring additional education of hospital staff on an annual basis. An extremely ill emergency department patient who may need a significant number of separately payable procedures, but only one or two minor interventions that are not separately payable, may require significant time and attention from hospital staff that is unrelated to the hospital resources generally required for the separately payable procedures. The guidelines may indicate that a low level emergency department visit code should be billed, while in fact the patient may require significantly more hospital resources than a mildly ill patient who received the same two minor interventions. We are open to further discussion and welcome public comments on the exclusion of separately payable services from the national visit guidelines and whether their inclusion could pose a risk of attributing the same hospital resources to both visits and separately payable services, potentially resulting in duplicate payments for those resources.

d. Some Interventions Appear Overvalued

Several interventions that we believe may be minor are valued at a high level in the guidelines. This could result in visits with relatively less resource intensive interventions being coded as high level visits, leading to an overall visit distribution that was skewed toward the high end. Claims data then would fail to reflect the differential hospital resources associated with hospital visits of five levels. For example, the AHA/AHIMA guidelines consider oxygen administration, described as initiation and/or adjustment from a baseline oxygen regimen, to be a mid level emergency department intervention, while we believe that the associated hospital resources could be more consistent with its characterization as a low level emergency department intervention. In another example, the AHA/AHIMA guidelines consider specimen collection(s), other than venipuncture and other separately payable services, to be a mid level clinic intervention, while we believe this may be more consistent with other low level clinic

interventions, depending upon the numbers and types of different specimens collected. We encourage specific comments on the levels assigned to various interventions in the guidelines, with the goal of differentiating five levels of services in a normal distribution, based on their respective hospital resources.

e. Concerns of Specialty Clinics

The AHA/AHIMA guidelines are unlikely to sufficiently address the concerns of various specialty clinics (for example, pain management clinics, oncology clinics, and wound care centers). Anecdotally, we have heard that the interventions listed in the AHA/AHIMA guidelines do not include many of the interventions commonly performed in specialty clinics and that some of the interventions in the guidelines would never be performed in certain types of clinics. Currently, each provider has its own set of guidelines, and we believe that some specialty clinics have customized guidelines to facilitate coding their visits at different levels based upon the specific hospital resources commonly used in visits to their clinics. While we prefer to have one model that can be applied nationally to each level of clinic visit code for which we make a specific OPPS payment, we are unsure as to whether one model can adequately characterize visit levels for all types of clinics. For example, we have been told that the most appropriate proxy for facility resource consumption in cancer care is staff time due to the intensive staff interactions required to care for patients with cancer, regardless of the reasons for their clinic visits. We are interested in comments regarding the feasibility of applying national guidelines to specialty clinic visits while ensuring appropriate OPPS payments for those services and suggestions for revisions to the guideline models posted that could improve their utility in reporting such visits.

f. Americans With Disabilities Act

We are concerned that the AHA/AHIMA guidelines' intervention related to the special needs of certain patients may be in violation of the Americans with Disabilities Act, as it may increase the visit level reported, thereby increasing a patient's copayment. Even if additional hospital resources are required to treat patients with disabilities, patients must not have additional financial liability for those services based on their disabilities.

g. Differentiation Between New and Established Patients, and Between Standard Visits and Consultations

The AHA/AHIMA guidelines do not differentiate between new versus established patients or consultations versus standard visits for clinic visits. During the summer 2002 APC Panel meeting, the APC Panel recommended that CMS not differentiate among visit types, specifically new, established, and consultation visits, for the purposes of clinic visit facility coding. Therefore, in the August 9, 2002 OPPS proposed rule, we proposed to accept the APC Panel's recommendation to create five new G-codes to replace the CPT new and established clinic visit and consultation E/M codes. We did not finalize the codes for CY 2003 because of concerns then about creating new G-codes without national guidelines.

During CY 2006 and earlier, there has not been a payment difference between new and established patient visits of the same level, as generally both were mapped to the same APC. The information describing the AHA/AHIMA guidelines indicates that only one set of guidelines was developed for five levels of codes for clinic visits, regardless of a patient's status as a new or established patient or the provision of a consultation visit. This approach may have been related to the lack of a payment differential for different types of clinic visits of the same level under the OPPS when those guidelines were developed. However, several years of hospital claims data regarding the median costs of the specific CPT clinic visit E/M codes consistently indicate that new patients generally are more resource intensive than existing patients across all visit levels, and that consultations are more resource intensive than standard visits. For example, based upon CY 2005 claims used by the OPPS for CY 2007 ratesetting, CPT code 99213, the level 3 clinic visit code for established patients, has a median cost of $63.04. CPT code 99203, the level 3 clinic visit code for new patients, has a median cost of $74.12. CPT code 99243, the level 3 consultation visit code, has a median cost of $84.14. Finally, CPT code 99273, the level 3 confirmatory consultation visit code which was deleted for CY 2006, had a median cost of $100.77. We encourage public comments that discuss the potential differences in hospital clinic resource consumption for new patient visits, established patient visits, and consultations. If there are significant additional hospital resources required to provide new patient visits or consultations, we are unsure whether the interventions in the AHA/AHIMA guidelines would reliably capture these additional resources.

h. Distinction Between Type A and Type B Emergency Departments

There are no AHA/AHIMA guidelines for the reporting of visits to Type B emergency departments that meet the EMTALA definition of a DED, but do not meet the proposed definition of a Type A emergency department, as discussed above. When the AHA and AHIMA created these guidelines, emergency departments that did not meet the CPT definition of emergency department were instructed to bill CPT clinic visit E/M codes. There was no distinction in reporting between emergency departments that, as DEDs, had an EMTALA obligation but did not meet the CPT definition of emergency department and outpatient hospital clinics that did not provide emergency services. If we finalize our proposal to create new G-codes for CY 2007 for Type B emergency departments to use in reporting visits, in the short run hospitals will use internal guidelines to determine their visit levels for Type B emergency department visits, as they will for visits to both clinics and Type A emergency departments. However, with the implementation of national hospital visit guidelines we will need to specify those guidelines to be used for the purposes of Type B emergency visit reporting. The AHA and AHIMA have not yet had the opportunity to consider the issue of Type B emergency visit reporting in their guidelines, and we welcome public comments to provide additional perspectives on the appropriate guidelines for reporting visit levels in these Type B emergency departments.

The public comments that we receive on this guidelines section of this proposed rule will be publicly available to the AHA and AHIMA and their expert panel, along with comments that we receive on the two versions of the guidelines posted on our Web site. We hope to receive input from them over the upcoming months to address the eight areas of concern that are discussed above, as well as other issues brought to our attention by the public. We understand that some issues will not be able to be fully addressed by their expert panel until we finalize our CY 2007 payment policies for visits in the OPPS. We plan to communicate progress on the development of OPPS visit guidelines through updates to the OPPS Web site, and we may post other versions of draft guidelines in order to solicit additional public input during CY 2007. When we post additional

materials to the web for purposes of providing information or soliciting further comments regarding national guidelines, we will update the public through all means practically available to us, including communications with professional associations, list-serves, etc. While we understand the interest of some hospitals in our moving quickly to promulgate national guidelines that will assure standardized reporting of outpatient hospital visit levels, we believe that the issues we have identified and others that may arise are important and require serious consideration prior to the implementation of national guidelines. Because of our commitment to provide hospitals with 6–12 months notice prior to implementation of national guidelines, we expect that we will not implement national guidelines prior to CY 2008. We acknowledge that, once implemented, the guidelines will require periodic review and updating based on factors such as changing medical practices, hospital experiences in reporting the codes, new payment policies under the OPPS, and median costs for levels of services calculated from claims data. We are hopeful that the information received from the AHA, AHIMA and others on such reviews would permit us to effectively, and in a timely manner, address emerging guideline implementation issues, as well as develop desirable future modifications to the guidelines based on hospitals' experiences reporting commonly provided visits. We believe that this ongoing system should provide the most successful approach to ensuring that OPPS national visit guidelines continue to facilitate consistent and standardized reporting of outpatient hospital visits, in a manner that is resource-based and supportive of appropriate OPPS payments for the efficient and effective provision of visits in hospital outpatient settings.

X. Proposed Payment for Blood and Blood Products

A. Background

(If you choose to comment on issues in this section, please include the caption ''Blood and Blood Products'' at the beginning of your comment.)

Since the implementation of the OPPS in August 2000, separate payments have been made for blood and blood products through APCs rather than packaging them into payments for the procedures with which they were administered. Hospital payments for the costs of blood and blood products, as well as the costs of collecting, processing, and storing blood and blood products, are made through the OPPS payments for specific blood product APCs. On April 12, 2001, CMS issued the original billing guidance for blood products to hospitals (Program Transmittal A–01–50). In response to requests for clarification of these instructions, CMS issued Program Transmittal 496 on March 4, 2005. The comprehensive billing guidelines in the Program Transmittal also addressed specific concerns and issues related to billing for blood-related services, which the public had brought to our attention.

In the CY 2000 OPPS, payments for blood and blood products were established based on external data provided by commenters due to limited Medicare claims data. From the CY 2000 OPPS to the CY 2002 OPPS, payment rates for blood and blood products were updated for inflation. For the CY 2003 OPPS, as described in the November 1, 2002 final rule with comment period (67 FR 66773), we applied a special adjustment methodology to blood and blood products that had significant reductions in payment rates from the CY 2002 OPPS to the CY 2003 OPPS, when median costs were first calculated from hospital claims. Using the adjustment methodology, we limited the decrease in payment rates for blood and blood products to approximately 15 percent. For the CY 2004 OPPS, as recommended by the APC Panel, we froze payment rates for blood and blood products at CY 2003 levels as we studied concerns raised by commenters and presenters at the August 2003 and February 2004 APC Panel meetings.

For the CY 2005 OPPS, we established new APCs that allowed each blood product to be assigned to its own separate APC, as several of the previous blood product APCs contained multiple blood products with no clinical homogeneity or whose product-specific median costs may not have been similar. Some of the blood product HCPCS codes were reassigned to the new APCs (Table 34 of the November 15, 2004 final rule with comment period (69 FR 65819)).

We also noted in the November 15, 2004 final rule with comment period, that public comments on previous OPPS rules had stated that the CCRs that were used to adjust charges to costs for blood products in past years were too low. Past commenters indicated that this approach resulted in an underestimation of the true hospital costs for blood and blood products. In response to these comments and APC Panel recommendations from its February 2004 and September 2004 meetings, we conducted a thorough analysis of the CY 2003 claims (used to calculate the CY 2005 APC payment rates) to compare CCRs between those hospitals reporting a blood-specific cost center and those hospitals defaulting to the overall hospital CCR in the conversion of their blood product charges to costs. As a result of this analysis, we observed a significant difference in CCRs utilized for conversion of blood product charges to costs for those hospitals with and without blood-specific cost centers. The median hospital blood-specific CCR was almost two times the median overall hospital CCR. As discussed in the November 15, 2004 final rule with comment period, we applied a methodology for hospitals not reporting a blood-specific cost center, which simulated a blood-specific CCR for each hospital that we then used to convert charges to costs for blood products. Thus, we developed simulated medians for all blood and blood products based on CY 2003 hospital claims data (69 FR 65816).

For the CY 2005 OPPS, we also identified a subset of blood products that had less than 1,000 units billed in CY 2003. For these low-volume blood products, we based the CY 2005 OPPS payment rate on a 50/50 blend of the CY 2004 OPPS product-specific OPPS median costs and the CY 2005 OPPS simulated medians based on the application of blood-specific CCRs to all claims. We were concerned that, given the low frequency in which these products were billed, a few occurrences of coding or billing errors may have led to significant variability in the median calculation. The claims data may not have captured the complete costs of these products to hospitals as fully as possible. This low-volume adjustment methodology also allowed us to further study the issues raised by commenters and by presenters at the September 2004 APC Panel meeting, without putting beneficiary access to these low-volume blood products at risk.

Overall, median costs from CY 2003 (used for the 2005 OPPS) to CY 2004 (used for the 2006 OPPS) were relatively stable, with a few significant increases and decreases from the CY 2005 adjusted median costs for some specific blood products. For the CY 2006 OPPS, we adopted a payment adjustment policy that limited significant decreases in APC payment rates for blood and blood products from the CY 2005 OPPS to the CY 2006 OPPS to not more than 5 percent. We applied this adjustment to 11 blood and blood product APCs for the CY 2006 OPPS, which we identified in Table 33 of the CY 2006 OPPS final rule with comment period. For the CY 2006 OPPS we set the final median costs for blood and blood products at the

greater of: (1) The simulated median costs calculated from the CY 2004 claims data; or (2) 95 percent of the CY 2005 OPPS adjusted median costs for these products, as reflected in Table 33 published in the CY 2006 OPPS final rule with comment period.

B. Proposed Policy Changes for CY 2007

For the CY 2007 OPPS, we are proposing to establish payment rates for blood and blood products by using the same simulation methodology described in the November 15, 2004 final rule with comment period (69 FR 65816), which utilized hospital-specific actual or simulated CCRs for blood cost centers to convert hospital charges for blood and blood products to costs. We continue to believe that using blood-specific CCRs applied to hospital claims data will result in payments that more fully reflect hospitals' true costs of providing blood and blood products than our general methodology of defaulting to the overall hospital CCR when more specific CCRs are unavailable.

The median costs for blood and blood products in this proposed rule are derived from the CY 2005 claims data and have the benefit of reflecting, in part, the clarifications about reporting that were provided through CMS Program Transmittal 496, which we issued on March 4, 2005. This instruction articulated and clarified many questions that had been raised by hospitals and others about how hospitals should report charges for blood and blood products. These instructions went into effect for services furnished on or after July 1, 2005, and therefore were in effect for the last 6 months of CY 2005. Thus, we expect that the reporting of charges and units for blood and blood products in CY 2005 has improved over past years, especially with respect to hospitals' inclusion of all charges related to the acquisition, processing, and handling of blood and blood products as specifically described in each of the relevant P-code descriptors. We believe that the median costs for blood and blood products from the CY 2005 claims data reflect this improved reporting of charges and units for these products, particularly with regard to the most commonly furnished blood and blood products.

Of the 34 blood products, median costs per unit (calculated using the simulated blood CCR methodology) rise for 23 of them compared to the CY 2006 final rule with comment period unadjusted median unit costs. These 23 products account for 92.4 percent of all units of blood products furnished in our CY 2005 claims data. As has been the case in the past, the low volume products (which we define as fewer than 1,000 units) show the most volatility. Of the 12 low volume products, 6 products have increases in their unit costs compared to their CY 2006 unadjusted median unit costs, and 6 products show decreases in their median unit costs compared to their CY 2006 unadjusted median unit costs. The low-volume products for which the medians decline compared to their unadjusted median costs in CY 2006 represent only 0.29 percent of the total units of blood products furnished in the CY 2005 OPPS claims data.

Fewer blood products increased in projected costs from CY 2006 to the proposed median costs for CY 2007 because we adjusted the CY 2006 median costs for blood and blood products. Of the 34 blood products, median costs rise for 19 of them compared to the CY 2006 OPPS adjusted median costs on which the CY 2006 payments were based (and which were adjusted to no less than 95 percent of the CY 2005 payment medians). These 19 products accounted for 91.6 percent of all units of blood products furnished in our CY 2005 claims data. Of the 12 low-volume products, 4 show increases in their median unit costs compared to the CY 2006 OPPS adjusted median unit costs, and 8 show decreases compared to their CY 2006 OPPS adjusted median unit costs. The low-volume products that show a decline in medians compared to their CY 2006 adjusted median costs represent only 0.4 percent of the total units of blood products reflected in the CY 2005 claims data.

We are proposing to set the payment rates for blood and blood products for CY 2007 based on the unadjusted median costs for blood and blood products which are derived from the CY 2005 claims data as we have described. We believe that, in most cases, the unadjusted unit costs developed by this process are valid reflections of the estimated median costs of furnishing these specific blood products, and that no adjustment is required to result in appropriate payments for blood and blood products in CY 2007. Under this proposed policy, based on the CY 2005 claims data, the projected payments would rise for approximately 92 percent of the blood product units paid under OPPS if patterns of furnishing blood products in CY 2007 were similar to those in CY 2005. The low-volume products whose median costs decline compared to their CY 2006 unadjusted median costs are furnished very rarely and by very few providers because, in part, more commonly available products may be used for similar clinical indications. We have no reason to believe that the median costs for low-volume products are not valid reflections of the costs of furnishing these low-volume services, particularly given that so few providers furnish them and it is their claims data that is used to develop the medians. We note, as well, that the median costs of several low-volume blood products show a significant increase for CY 2007. We welcome public comments on this issue.

Displayed in Table 39 is the list of blood product HCPCS codes with their proposed CY 2007 payment medians.

TABLE 39.—PROPOSED CY 2007 PAYMENT MEDIANS FOR BLOOD AND BLOOD PRODUCTS

HCPCS code	SI	APC	Short description	Proposed CY 2007 units	Proposed CY 2007 OPPS median unit cost	CY 2006 unadjusted median cost	CY 2006 adjusted median cost
P9010	K	0950	Whole blood for transfusion, per unit	2060	$134.80	$117.91	$117.91
P9011	K	0967	Blood split unit, specify amount	136	136.42	82.50	82.50
P9012	K	0952	Cryoprecipitate each unit	4155	52.94	40.33	47.10
P9016	K	0954	RBC leukocytes reduced, each unit	556100	177.51	163.16	163.16
P9017	K	9508	Plasma 1 donor frz w/in 8 hr, each unit	40113	72.12	70.40	70.40
P9019	K	0957	Platelets, each unit	25796	60.49	51.50	51.50
P9020	K	0958	Platelet rich plasma unit	657	156.49	277.42	277.42
P9021	K	0959	Red blood cells unit	145507	129.99	121.48	121.48
P9022	K	0960	Washed red blood cells unit	2455	216.35	172.40	189.22
P9023	K	0949	Frozen plasma, pooled, sd, each unit	388	55.96	60.38	76.15

TABLE 39.—PROPOSED CY 2007 PAYMENT MEDIANS FOR BLOOD AND BLOOD PRODUCTS—Continued

HCPCS code	SI	APC	Short description	Proposed CY 2007 units	Proposed CY 2007 OPPS median unit cost	CY 2006 unadjusted median cost	CY 2006 adjusted median cost
P9031	K	1013	Platelets leukocytes reduced, each unit	19368	94.61	98.30	98.30
P9032	K	9500	Platelets, irradiated, each unit	4579	129.45	73.46	86.55
P9033	K	0968	Platelets leukoreduced irrad, each unit	4802	130.89	102.18	150.58
P9034*	K	9507	Platelets, pheresis, each unit	9292	465.60	434.01	434.01
P9035	K	9501	Platelet pheresis leukoreduced, each unit	40933	490.51	493.12	493.12
P9036	K	9502	Platelet pheresis irradiated, each unit	1476	413.58	317.43	325.87
P9037	K	1019	Plate pheresis leukoredu irrad, each unit	17766	616.68	581.01	581.01
P9038	K	9505	RBC irradiated, each unit	4130	201.36	147.47	147.47
P9039	K	9504	RBC deglycerolized, each unit	818	352.72	343.44	343.44
P9040	K	0969	RBC leukoreduced irradiated, each unit	57857	228.76	218.04	218.04
P9043	K	0956	Plasma protein fract, 5%, 50ml	430	24.81	67.94	67.94
P9044	K	1009	Plasma, cryoprecipitate reduced, each unit	5868	80.23	74.52	74.52
P9048	K	0966	Plasma protein fract, 5%, 250ml	398	193.39	127.36	315.70
P9050	K	9506	Granulocytes, pheresis unit	495	253.43	245.14	994.64
P9051	K	1010	Blood, l/r, cmv-neg, each unit	3364	135.83	207.72	207.72
P9052	K	1011	Platelets, hla-m, l/r, unit	1809	649.06	609.48	609.48
P9053	K	1020	Plt, pher, l/r cmv-neg, irr, each unit	895	722.82	654.13	654.13
P9054	K	1016	Blood, l/r, froz/degly/wash, each unit	493	89.33	89.73	261.93
P9055	K	1017	Plt, aph/pher, l/r, cmv-neg, each unit	534	379.91	526.00	526.00
P9056	K	1018	Blood, l/r, irradiated, each unit	3720	134.43	162.42	178.37
P9057	K	1021	RBC, frz/deg/wsh, l/r, irrad, each unit	71	427.35	345.53	345.53
P9058	K	1022	RBC, l/r, cmv-neg, irrad, each unit	1965	264.47	256.76	266.89
P9059	K	0955	Plasma, frz between 8–24hour, each unit	3118	73.28	74.70	74.70
P9060	K	9503	Fr frz plasma donor retested, each unit	283	73.60	94.72	94.72

*After removal of two claims with grossly excessive units.

XI. Proposed OPPS Payment for Observation Services

(If you choose to comment on issues in this section, please include the caption ''OPPS: Observation Services'' at the beginning of your comment.)

Observation care is a well-defined set of specific, clinically appropriate services that include ongoing short-term treatment, assessment, and reassessment, before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after surgery and to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement.

For CY 2006, we adopted two coding changes that affect how observation services are reported, and we made changes in the OCE to shift from individual providers to the OPPS claims processing systems the determination of whether or not observation services are separately payable or packaged. Observation services reported using HCPCS code G0378 (Hospital observation services, per hour) that are eligible for separate payment map to APC 0339 (Observation). The CY 2006 payment rate for APC 0339 is $425.08. The proposed CY 2007 median cost for APC 0339 is $442.16, reflecting relative stability in hospital costs for separately payable observation care. Direct admission to observation (G0379), when separately payable, is currently assigned for payment to APC 0600 (Low Level Clinic Visit) with a CY 2006 payment rate of $52.37. As discussed below, for CY 2007 we are proposing to assign direct admission to observation, when separately payable, to APC 0604 (Low Level Clinic Visit). The CY 2007 proposed median cost for APC 0604 is $49.93.

As we stated in the November 10, 2005 OPPS final rule with comment period (70 FR 68688), the changes that we adopted for CY 2006 were intended to ensure more consistent hospital billing for observation services in order to guide our future analyses of payment for observation care and to simplify how observation services are reported and paid. We refer readers to the CY 2006 OPPS final rule with comment period for a detailed discussion of the G-codes for observation services and the OCE logic changes implemented for CY 2006 (70 FR 68688), and to Program Transmittal 787, issued on December 16, 2005, in which we updated Chapter 4, Section 290 of the Medicare Claims Processing Manual (Pub. 100–04) to reflect the CY 2006 changes and to provide additional guidance to contractors and hospitals.

During the APC Panel's March 2006 meeting, the Observation Subcommittee did not make any recommendations to the Panel other than to request its review of additional data on observation services at the Panel's 2007 winter meeting. The APC Panel adopted the Observation Subcommittee's report and recommended no changes to the criteria for separate payment for observation services or to the coding and payment methodology for observation services.

Therefore, for CY 2007, we are proposing to continue applying the criteria for separate payment for observation services and the coding and payment methodology for observation services that were implemented in CY 2006, with one exception. In section IX. of this preamble, we are proposing changes in coding and payment for clinic and emergency room visits. As part of these proposed changes, low level clinic visits would move from APC 0600 to APC 0604, with a CY 2007 proposed median cost of $49.93. Under the circumstances where direct admission to observation is separately payable, we are proposing to assign HCPCS code G0379 to APC 0604 consistent with its CY 2006 placement in the APC for Low Level Clinic Visits.

As we stated in Program Transmittal A–02–129 released in January 2003, we

will continue to include in the October quarterly update of the OPPS any changes to the list of ICD–9–CM codes required for separate payment of HCPCS code G0378 resulting from the October 1 annual update of ICD–9–CM codes. The currently applicable ICD–9–CM codes are listed in Table 34 of the CY 2006 OPPS final rule with comment period (70 FR 68692), and any changes to that list will be included in the CY 2007 OPPS final rule with comment period.

XII. 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 outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

In the April 7, 2000 final rule with comment period, we identified procedures that are typically provided only in an inpatient setting and, therefore, would not be paid by Medicare under the OPPS (65 FR 18455). These procedures comprise what is referred to as the ''inpatient list.'' The inpatient list specifies those services that are only paid when provided in an inpatient setting because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we discussed in the April 7, 2000 final rule with comment period (65 FR 18455) and the November 30, 2001 final rule (66 FR 59856), we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

- Most outpatient departments are equipped to provide the services to the Medicare population.
- The simplest procedure described by the code may be performed in most outpatient departments.
- The procedure is related to codes that we have already removed from the inpatient list.

In the November 1, 2002 final rule with comment period (67 FR 66741), we removed 43 procedures from the inpatient list for payment under OPPS. We also added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

- We have determined that the procedure is being performed in numerous hospitals on an outpatient basis; or
- We have determined that the procedure can be appropriately and safely performed in an ambulatory surgical center (ASC) and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.

We believe that these additional criteria help us to identify procedures that are appropriate for removal from the inpatient list.

B. Proposed Changes to the Inpatient Only List

(If you choose to comment on issues in this section, please include the caption ''Inpatient Only Procedures'' at the beginning of your comment.)

For CY 2007 OPPS, we used the same methodology as described in the November 15, 2004 final rule with comment period (69 FR 65835) to identify a subset of procedures currently on the inpatient list that are being widely performed on an outpatient basis. These procedures were then clinically reviewed for possible removal from the inpatient list. We solicited input from the APC Panel on the appropriateness of the removal of seven procedures from the inpatient list at the March 1, 2006 APC Panel meeting. During CY 2006, we have received no other candidate HCPCS codes for removal from the OPPS inpatient list based on recommendations from the public. The APC Panel recommended that one of the procedures (CPT code 21181, Reconstruction by contouring of benign tumor of cranial bones, extracranial) be removed from the list and that we solicit approval from the relevant physician specialty societies prior to proposing removal of the other procedures.

Consistent with our established policy for removing procedures from the inpatient list, we rely on our utilization data and clinical staff input in determining which procedures are candidates for removal. We believe that our policy of proposing the procedures for removal and soliciting comments from the public, which includes physician specialty societies, is the most appropriate process to receive input from the public on this issue. Rather than solicit approval from a select group (for example, specific physician specialty societies), we believe that solicitation of comments from all interested parties is more consistent with meeting our obligation to the public regarding outpatient services provided by hospitals. The utilization data and clinical review findings for the eight procedures support our proposal to remove them from the inpatient list, and therefore, we are proposing to remove these procedures from the inpatient list and to assign them to clinically appropriate APCs, as shown in Table 40. The changes to the inpatient list would be effective for services furnished on or after January 1, 2007.

TABLE 40.—PROPOSED PROCEDURE CODES TO REMOVE FROM INPATIENT LIST AND PROPOSED APC ASSIGNMENTS, EFFECTIVE JANUARY 1, 2007

HCPCS code	Long descriptor	Proposed new APC assignment	Current status indicator	Proposed new status indicator
16035	Escharotomy; initial incision	0016	C	T
21181	Reconstruction by contouring of benign tumor of cranial bones, extracranial	0254	C	T
22851	Apply spine prosth device	0049	C	T
57292	Construction of artificial vagina; with graft	0195	C	T
57335	Vaginoplasty for intersex state	0195	C	T
61720	Creation of lesion by stereotactic method, including burr holes and localizing and recording techniques, single of multiple stages; globus pallidus or thalamus.	0221	C	T
62000	Elevation of depressed skull fracture; simple extradural	0254	C	T

TABLE 40.—PROPOSED PROCEDURE CODES TO REMOVE FROM INPATIENT LIST AND PROPOSED APC ASSIGNMENTS, EFFECTIVE JANUARY 1, 2007—Continued

HCPCS code	Long descriptor	Proposed new APC assignment	Current status indicator	Proposed new status indicator
64804	Sympathectomy, cervicothoracic	0220	C	T

C. Proposed CY 2007 Payment for Ancillary Outpatient Services When Patient Expires (–CA Modifier)

(If you choose to comment on issues in this section, please include the caption ''Ancillary Outpatient Services'' at the beginning of your comment.)

1. Background

In the November 1, 2002 final rule with comment period (67 FR 66798), we discussed the creation of a new HCPCS modifier –CA to address situations where a procedure on the OPPS inpatient list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, and the patient dies before being admitted as an inpatient. In Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of this modifier when submitting a claim on bill type 13x for a procedure that is on the inpatient list and assigned the payment status indicator (SI) ''C'' (to indicate inpatient services that are not paid under the OPPS). Conditions to be met for hospital payment for a claim reporting a service billed with modifier –CA include a patient with an emergent, life-threatening condition on whom a procedure on the inpatient list is performed on an emergency basis to resuscitate or stabilize the patient. For CY 2003, a single payment for otherwise payable outpatient services billed on a claim with a procedure appended with this new –CA modifier was made under APC 0977 (New Technology Level VIII, $1,000–$1,250), due to the lack of available claims data to establish a payment rate based on historical hospital costs.

As discussed in the November 7, 2003 final rule with comment period, we created APC 0375 (Ancillary Outpatient Services When Patient Expires) to pay for services furnished on the same date as a procedure with SI ''C'' and billed with the modifier –CA (68 FR 63467) because we were concerned that payment under a New Technology APC would not result in an appropriate payment. Payment under a New Technology APC is a fixed amount that does not have a relative payment weight and, therefore, is not subject to recalibration based on hospital costs. In the absence of hospital claims data to determine costs, the clinical APC 0375 payment rate for CY 2004 was set at $1,150, which was the payment amount for the newly structured New Technology APC that replaced APC 0977.

For CYs 2005 and 2006, the payment rates for APC 0375 for services billed on the same date as a ''C'' status procedure appended with modifier -CA were established in accordance with the same methodology we followed to set payment rates for the other procedural APCs in those years, based on the relative payment weight calculated for APC 0375. For APC 0375 specifically, we calculated the relative payment weight from all claims reporting a ''C'' status procedure appended with modifier –CA, using charge data from the relevant calendar year claims for line items with a HCPCS code and status indicator ''V,'' ''S,'' ''T,'' ''X,'' ''N,'' ''K,'' ''G,'' and ''H,'' in addition to charges for revenue codes without a HCPCS code. We continued to make one payment in CYs 2005 and 2006 under APC 0375 for the services that met the specific conditions discussed in previous rules for using modifier –CA.

In the CY 2006 final rule with comment period (70 FR 68700) we discussed our concern about the large increase in the volume of hospital claims billed with modifier –CA from CY 2003 to CY 2004, growing from 18 to 300 claims over that 1-year time period. We acknowledged that because modifier –CA was first introduced for CY 2003, the use of the modifier in CYs 2003 and 2004 may have reflected such an increase due to hospitals' learning curve with respect to the modifier's appropriate use on claims for services payable under the OPPS. We also expressed some concern that numerous claims reflected unanticipated examples of ''C'' status procedures reported with modifier –CA that may not have been provided to patients with emergency life threatening conditions, where the inpatient procedure was performed on an emergency basis to resuscitate or stabilize the patient. We promised to monitor CY 2005 claims data for similar increases.

Our review of the CY 2005 claims data revealed a decrease in the use of modifier –CA in comparison with CY 2004 claims. In CY 2005 there were only 210 claims submitted reporting modifier –CA. Because of the diverse individual clinical scenarios where modifier –CA may be appropriately reported, we expect some variation from year to year in the number of OPPS claims reporting the modifier. It would appear that the hospital learning curve regarding use of modifier –CA may have been completed over the past 3 year period, and that we may expect relatively consistent reporting of this modifier in future years. We wish to particularly note that not only was there no increase in the number of claims reporting modifier –CA in CY 2005, but there were also far fewer apparently inappropriate instances of use. Our CY 2005 claims data show the majority of reporting of modifier –CA was in association with what were likely to have been urgent interventions, including the insertion of intra-aortic balloon assist devices and exploratory laparotomies. We believe that the data support our speculation that much of the increase in reporting of the modifier observed in CY 2004 data was a result of hospitals' learning curve regarding the appropriate use of the modifier.

2. Proposed Policy for CY 2007

We do not propose any change to our policies regarding reporting of modifier –CA for CY 2007, or to our payment policy regarding APC 0375. Therefore, for CY 2007, we are proposing that hospitals continue reporting modifier –CA only under circumstances described in section VI. of Transmittal A–02–129, which provided specific billing guidance for the use of modifier -CA. In addition, we are proposing to continue to make one payment under APC 0375 for the services that meet the specific conditions discussed in previous rules for using modifier –CA, based on calculation of the relative payment weight for APC 0375 as described above. We applaud hospitals' improved billing practices and as before, will continue to monitor use of modifier –CA. The CY 2007 proposed APC 0375 median cost is $3,539, significantly increased from the $2,527

median cost proposed in the CY 2006 proposed rule. This variation in median costs, however, is expected because the specific cases that populate the claims data for APC 0375 likely exhibit only limited clinical and resource homogeneity among all the claims attributable to that APC in a given year and across different years for the same APC. The cost variation of APC 0375 from year to year could be expected because APC 0375 is unique in the OPPS and, by its definition, should always be limited in its use.

XIII. Proposed Nonrecurring Policy Changes

A. Removal of Comprehensive Outpatient Rehabilitation Facility (CORF) Services From the List of Services Paid under the OPPS

(If you choose to comment on issues in this section, please include the caption ''CORF Services'' at the beginning of your comment.)

We are proposing to make a technical change to the regulations at 42 CFR 419.21(d) to remove from the list of services paid under the OPPS certain services furnished by a comprehensive outpatient rehabilitation facility (CORF) when they are provided outside the patient's plan of care (for example, hepatitis B vaccine). Section 1834(k) of the Act, as added by section 4541(a) of Pub. L. 105–33 (BBA), requires that CORF services be paid using the lesser of actual charges or a fee schedule amount. We instructed fiscal intermediaries to use the Medicare Physician Fee Schedule (MPFS) for payments to CORFs. We have not required CORF cost reports, or paid CORFs under the OPPS, since 2001. The proposed revision of the regulation to delete certain CORF services from the list of specified services paid under the OPPS is necessary to conform the regulations to the statutory requirement.

B. Addition of Ultrasound Screening for Abdominal Aortic Aneurysms (AAAs) (Section 5112 of Pub. 109–171 (DRA))

(If you choose to comment on the issues in this section, please include the caption ''AAA Screening'' at the beginning of your comment.)

1. Background

Section 5112 of the Deficit Reduction Act of 2005, Pub. L. 109–171 (DRA), amended section 1861 and related provisions of the Act to provide for coverage under Part B of ultrasound screening for abdominal aortic aneurysms (AAAs), effective for services furnished on or after January 1, 2007, subject to certain eligibility and other limitations. The proposed rule governing this new Part B coverage will be established through a separate document, specifically the CY 2007 Medicare Physician Fee Schedule proposed rule. We refer readers to that document for a full and complete explanation of this coverage provision.

2. Proposed Assignment of New HCPCS Code for Payment of Ultrasound Screening for Abdominal Aortic Aneurysm (AAA) (Section 5112)

There is no current CPT code that specifically describes an ultrasound screening for AAA. Therefore, we are proposing to establish the following new HCPCS code, GXXXX (Ultrasound, B-scan and or real time with image documentation; for abdominal aortic aneurysm (AAA) screening) to be used to bill for the new service under both the Medicare Physician Fee Schedule and the OPPS. As required by the statute, Medicare will allow payment for a one-time only screening examination, and this screening test will be available even if the qualifying patient does not present signs or symptoms of disease or illness. In addition, this code does not include any other preventive services that are currently separately covered and paid under the Medicare Part B screening benefits. When these other preventive services are performed, they should be reported using the existing appropriate codes.

We are proposing to base the payment for GXXXX on equivalent hospital resources and intensity to those contained in CPT code 76775, which is assigned to APC 0266 (Level II Diagnostic and Screening Ultrasound) under the OPPS for CY 2007. We believe that the hospital costs associated with the screening study are very similar to those of the limited retroperitoneal ultrasound diagnostic examination and, therefore, that the screening and diagnostic studies should be assigned to the same clinical APC for reasons of clinical and resource homogeneity. Thus, we are proposing to assign GXXXX to APC 0266 with a median cost of $98.59 for CY 2007.

3. Handling of Comments Received in Response to This Proposal

We noted previously that ultrasound screening for AAAs is also addressed in detail in our proposed rule to update the Medicare Physician Fee Schedule for CY 2007. We will respond to all comments regarding the proposed elements required for the ultrasound screening for AAA, whether the examination is performed in a physician's office or an outpatient hospital setting, and the exception from the Part B annual deductible, in the final rule implementing the Medicare Physician Fee Schedule for CY 2007. We will respond to all comments regarding payment for GXXXX under the OPPS in the CY 2007 OPPS final rule.

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

(If you choose to comment on issues in this section, please include the caption ''CAHs: Emergency Medical Screening'' at the beginning of your comment.)

A. Background

Section 1820 of the Act, as amended by section 4201 of the Balanced Budget Act of 1997, provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs), under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participations (CoPs) under 42 CFR Part 485, Subpart F, will be certified as CAHs by CMS. The MRHFP replaced the Essential Access Community Hospital (EACH)/Rural Primary Care Hospital (RPCH) program.

B. Proposed Policy Change

Existing regulations governing CAHs at § 485.618(d) require on-call doctors and nonphysician practitioners who may be attending to urgent/acute medical problems in other areas of the CAH or outside the CAH to report to the CAH's emergency room within 30 minutes (60 minutes if the CAH is located in a frontier or remote area or permissible under the State's rural health care plan) to see a patient in the emergency room of a CAH. Often, these patients do not have emergency medical conditions. With changes to the regulations at § 489.24 that implement the Emergency Medical Treatment and Labor Act (EMTALA) over the past few years, some practitioners have noted to CMS that the requirements regarding who should respond to calls to see patients who present to the emergency department of a CAH are more stringent than for general hospitals.

The provider community recently requested that we change the emergency on-call personnel requirements for CAHs to conform to the regulatory changes published in the FY 2005 IPPS final rule (69 FR 49271). In response to this request, we are proposing to revise the current CAH CoPs to align the emergency medical screening requirements in CAHs with those applicable to acute care hospitals. The

proposed change would allow registered nurses, in addition to the personnel currently required at § 485.618(d), to serve as qualified medical personnel to screen individuals who present to the CAH emergency room if the nature of the patient's request is within the registered nurse's scope of practice under State law and such screening is permitted by the CAH's bylaws. This proposed change would effectively eliminate the need for a doctor or mid-level practitioner to report to the emergency department to attend to a nonemergent request for medical care if a registered nurse is on site at the CAH and has made a determination that the care needed is of a non-emergent nature.

The EMTALA statute at section 1867 of the Act states that a hospital in this context must provide an appropriate (suitable for the symptoms presented) medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition exists (section 1866(a)(1)(I) of the Act imposes the section 1867 requirements on a CAH). The EMTALA regulations at § 489.24(a) state that the examination must be conducted by qualified medical personnel. These qualified medical personnel designated to perform medical screening examinations must be determined qualified by the hospital's bylaws or rules and regulations and must be practicing within the scope of practice under State law.

The regulations at § 489.24(c) relating to the use of dedicated emergency department for nonemergency services were added in September 2003 (68 FR 53262) to state that if an individual goes to a hospital's dedicated emergency department to request medical treatment, and the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate to determine that the individual does not have an emergency medical condition.

Although EMTALA also applies to CAHs, the CoP for CAH emergency services (§ 485.618(d)) states that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist with training or experience in emergency care must be on call and available onsite at a CAH within a specified timeframe. These are the CAH personnel who would be available to conduct an emergency medical screening under § 489.24(c). In contrast, the emergency services CoP for acute care hospitals at § 482.55 does not specify the type of personnel who must be available to provide emergency services and who would, therefore, perform assessments and screenings. The regulation states only that the services must be organized and supervised under the direction of a qualified member of the medical staff. Therefore, an acute care hospital may, if it chooses, have protocols that permit a registered nurse to conduct specific emergency medical screenings if the nature of the individual's request for examination and treatment is within the scope of practice of a registered nurse. For emergencies that are outside of a registered nurse's scope of practice, another qualified medical personnel (operating within his or her scope of practice under State law) would conduct the emergency medical screening.

We are proposing to revise the CAH standard at § 485.618(d) to allow a CAH, if applicable, the flexibility of including a registered nurse, with training and experience in emergency care and who is on site at the CAH, as one of the qualified medical personnel available for emergency services, particularly emergency medical screenings, if the nature of the individual's request makes clear that the medical condition is not of an emergency nature and the individual's request for examination and treatment is within the registered nurse's scope of practice under State law. If the registered nurse begins the emergency medical screening and determines that the nature of the individual's conditions is outside his or her scope of practice under State law, the physician, physician assistant, nurse practitioner or a clinical nurse specialist must be contacted to see the patient within 30 or 60 minutes to conduct the emergency medical screening and provide stabilizing treatment. If the registered nurse knows initially that the medical screening for the presenting complaint is outside the applicable scope of practice under State law, the physician or other nonphysician practitioner must see the individual within the 30 or 60 minute timeframes (as currently specified in § 485.618(d)(1)).

We recognize that not all CAHs will be able to utilize this flexibility. Some State licensure boards have stated that it is not within the authorized scope of practice for a registered nurse to independently perform an appropriate emergency medical screening for the purpose of determining if an emergency medical condition exists. However, the licensure boards in these States further maintain that it is within the scope of practice for a registered nurse to assess the health status of an individual to determine a nonemergent condition and to provide nursing care or to refer the individual to appropriate medical resources. Therefore, based on State law, some CAHs will not be able to designate registered nurses as qualified medical personnel under our proposed revision to the regulations governing CAHs. However, as we wish to provide flexibility to CAHs and to be consistent with existing EMTALA policy, we are proposing the revision to the regulation at § 485.618(d).

XV. Proposed OPPS Payment Status and Comment Indicators

A. Proposed CY 2007 Status Indicator Definitions

(If you choose to comment on issues in this section, please include the caption ''OPPS Status Indicator'' at the beginning of your comment.)

The OPPS payment status indicators (SIs) that we assign to HCPCS codes and APCs play an important role in determining payment for services under the OPPS. They indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. Our proposed CY 2007 status indicator assignments for APCs and HCPCS codes are shown in Addendum A and Addendum B, respectively. We are proposing to use the status indicators and definitions that are listed in Addendum D1, which we discuss below in greater detail:

1. Proposed Payment Status Indicators To Designate Services That Are Paid Under the OPPS

Indicator	Item/code/service	OPPS payment status
G	Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment includes pass-through amount.
H	(1) Pass-Through Device Categories	(1) Separate cost-based pass-through payment; Not subject to coinsurance.
	(2) Radiopharmaceutical Agents	(2) Separate cost-based non-pass-through payment.

Indicator	Item/code/service	OPPS payment status
K	(1) Non-Pass-Through Drugs and Biologicals	(1) Paid under OPPS; Separate APC payment.
	(2) Brachytherapy Sources	(2) Paid under OPPS; Separate APC payment.
K	(3) Blood and Blood Products	(3) Paid under OPPS; Separate APC payment.
N	Items and Services Packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.
Q	Packaged Services Subject to Separate Payment Under OPPS Payment Criteria.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on OPPS payment criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
X	Ancillary Services	Paid under OPPS; Separate APC payment.

2. Proposed Payment Status Indicators To Designate Services That Are Paid Under a Payment System Other Than the OPPS

Indicator	Item/code/service	OPPS payment status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example. • Ambulance Services. • Clinical Diagnostic Laboratory Services. • Non-Implantable Prosthetic and Orthotic Devices. • EPO for ESRD Patients. • Physical, Occupational, and Speech Therapy. • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital. • Diagnostic Mammography. • Screening Mammography.	Not paid under OPPS. Paid by fiscal intermediaries under a fee schedule or payment system other than OPPS.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
F	Corneal Tissue Acquisition; Certain CRNA Services; and Hepatitis B Vaccines.	Not paid under OPPS. Paid at reasonable cost.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary	Not paid under OPPS.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.

3. Proposed Payment Status Indicators To Designate Services That Are Not Recognized Under the OPPS but That May Be Recognized by Other Institutional Providers

Indicator	Item/code/service	OPPS payment status
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x,13x, and 14x).	Not paid under OPPS. • May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x, and 14x) may be available.

4. Proposed Payment Status Indicators to Designate Services That Are Not Payable by Medicare

Indicator	Item/code/service	OPPS payment status
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: • That are not covered by Medicare based on statutory exclusion. • That are not covered by Medicare for reasons other than statutory exclusion. • That are not recognized by Medicare but for which an alternate code for the same item or service may be available. • For which separate payment is not provided by Medicare.	Not paid under OPPS or any other Medicare payment system.

To make it more relevant to the proposed update of the OPPS, we are displaying in Addendum B of this proposed rule those HCPCS codes that describe items or services that are payable under the OPPS as well as nonpayable codes for which we are proposing a change in status. Status indicators for items and services that are payable under the OPPS are listed in section XV.A.1 of this preamble.

A complete listing of HCPCS codes with OPPS payment status indicators and APC assignments proposed for CY 2007 is available electronically on the CMS Web site.

B. Proposed CY 2007 Comment Indicator Definitions

(If you choose to comment on issues in this section, please include the caption ''OPPS Comment Indicator'' at the beginning of your comment.)

In the November 15, 2004 final rule with comment period (69 FR 65827 and 65828), we made final our policy to use three comment indicators to identify in an OPPS final rule the assignment status of a specific HCPCS code to an APC and the timeframe when comments on the HCPCS APC assignment will be accepted. These three comment indicators are listed below:

• ''NF''—New code, final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.

• ''NI''—New code, interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

In the November 10, 2005 final rule with comment period (70 FR 68702 and 68703), we adopted a new comment indicator:

• ''CH''—Active HCPCS codes in current and next calendar year; status indicator and/or APC assignment have changed.

We implemented comment indicator ''CH'' to designate a change in payment status indicator and/or APC assignment for HCPCS codes in Addendum B of the CY 2006 final rule with comment period. We also stated that codes flagged with the ''CH'' indicator in that final rule would not be open to comment because the changes were previously subject to comment during the proposed rule comment period. We are proposing to continue that policy in the CY 2007 OPPS final rule. When used in an OPPS final rule, the ''CH'' indicator is only intended to facilitate the public's review of changes made from one calendar year to another. We are proposing to use the ''CH'' indicator in the CY 2007 final rule to indicate HCPCS codes for which the status indicator and/or APC assignment will change in CY 2007. However, only HCPCS codes with comment indicator ''NI'' in the CY 2007 OPPS final rule would be subject to comment during the final rule comment period.

We also are proposing to use the ''CH'' indicator to call attention to changes in payment status indicator and/or APC assignment in this proposed rule to update the OPPS for CY 2007. We believe that using the ''CH'' indicator in this proposed rule will facilitate the public's review of the changes that we are proposing to make final in CY 2007. Use of the ''CH'' indicator in the proposed rule is significant because it highlights changes that are subject to comment during the proposed rule comment period.

The three comment indicators that we are proposing to implement in CY 2007 and their definitions are listed in Addendum D2 of this proposed rule.

XVI. OPPS Policy and Payment Recommendations

(If you choose to comment on issues in this section, please include the caption ''Policy and Payment Recommendations'' at the beginning of your comment.)

A. MedPAC Recommendations

The Medicare Payment Advisory Commission (MedPAC) submits reports to Congress in March and June that summarize payment policy recommendations. The March 2006 MedPAC report included the following recommendation relating specifically to the hospital OPPS:

Recommendation 2A: The Congress should increase payment rates for the acute inpatient and outpatient prospective payment systems in 2007 by the projected increase in the hospital market basket index less half of the Commission's expectation for productivity growth. A discussion regarding updates to the market basket is included in section II.C. (''Proposed OPPS Conversion Factor Update for 2007'') of this preamble.

B. APC Panel Recommendations

Recommendations made by the APC Panel are discussed in sections of this preamble that correspond to topics addressed by the APC Panel. Minutes of the APC Panel's March 1–2, 2006 meeting are available online at *http://www.cms.hhs.gov/FACA/05_AdvisoryPanelonAmbulatoryPaymentClassificationGroups.asp.*

C. GAO Recommendations

A discussion of the October 31, 2005 GAO letter of comment on proposed 2006 specified covered outpatient drug (SCOD) rates (GAO–06–17R ''Comments on Proposed 2006 SCOD Rates'') is contained in section V.3.B.a. of this preamble.

A discussion of the April 2006 GAO report entitled ''Medicare Hospital Pharmaceuticals: Survey Shows Price Variation and Highlights Data Collection Lessons and Outpatient Rate-setting Challenges for CMS'' (GAO–06–372) is contained in section V.3.B.a. of this preamble.

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

A. ASC Background

1. Legislative History

Section 1832(a)(2)(F)(i) of the Act provides that benefits under the Medicare Supplementary Medical Insurance program (Part B) include payment for facility services furnished in connection with surgical procedures the Secretary specifies which are performed in an ASC. To participate in the Medicare program as an ASC, a

facility must meet the standards specified in section 1832(a)(2)(F)(i) of the Act; in 42 CFR 416, subpart B of our regulations, which sets forth general conditions and requirements for ASCs; and in 42 CFR 416, subpart C of our regulations, which provides specific conditions for coverage for ASCs.

The ASC services benefit was enacted by Congress through the Omnibus Reconciliation Act of 1980 (Pub. L. 96–499). For a detailed discussion of the legislative history related to ASCs, we refer readers to the June 12, 1998 proposed rule (63 FR 32291).

Section 626(b) of Pub. L. 108–173, repealed the requirement formerly found in section 1833(i)(2)(A) of the Act that the Secretary conduct a survey of ASC costs for purposes of updating ASC payment rates and, instead, requires the Secretary to implement a revised ASC payment system, to be effective not later than January 1, 2008. Section XVIII. of this proposed rule contains our proposal for a revised ASC payment system that would be implemented on January 1, 2008.

Section 5103 of Pub. L. 109–171, amended section 1833(i)(2) of the Act by adding a new subparagraph (E) to place a limitation on payments for surgical procedures in ASCs. If the standard overhead amount under section 1833(i)(2)(A) of the Act for a facility service for such procedure, without application of any geographic adjustment exceeds the Medicare OPPS payment amount for the service for that year, without application of any geographic adjustment, the Secretary shall substitute the OPPS payment amount for the ASC standard overhead amount. This provision applies to surgical procedures furnished in ASCs on or after January 1, 2007, and before the effective date of the revised ASC payment system.

We discuss in section XVII.C. of this preamble, the regulatory changes that we are proposing for our current ASC payment system. In section XVII.D. of this proposed rule, we are addressing the changes in payment to ASCs mandated by section 5103 of Pub. L. 109–171, as well as additions to and deletions from the list of Medicare-approved ASC procedures to be implemented January 1, 2007, prior to implementation of the revised ASC payment system. In addition, in section XVII.E. of this preamble, we are proposing changes in the process to review payment adjustments for insertion of new technology intraocular lenses (NTIOLs). The CY 2007 OPPS final rule that we issue in the fall of 2006 will implement changes to the ASC list that will go into effect January 1, 2007. In section XVIII. of this preamble, we are proposing a revised payment system for ASCs to be implemented effective January 1, 2008, including revisions to the ASC list for CY 2008, the ratesetting method, and the applicable ASC regulations to incorporate the requirements and payments for ASC facility services under the proposed revised ASC system. We expect that a final rule implementing the revised ASC payment system will be published separately in the spring of 2007.

2. Current Payment Method

There are two primary elements in the total cost of performing a surgical procedure: (a) The cost of the physician's professional services to perform the procedure and (b) the cost of items and services furnished by the facility where the procedure is performed (for example, surgical supplies, equipment, and nursing services). Payment for the first element is made under the Medicare physician fee schedule. This proposed rule addresses the second element, the payment of facility fees for ASC services. This proposed rule also addresses coverage of ASC services.

Under the current ASC facility services payment system, the ASC payment rate is a standard overhead amount established on the basis of our estimate of a fee that takes into account the costs incurred by ASCs generally in providing facility services in connection with performing a specific procedure. The report of the Conference Committee accompanying section 934 of the Omnibus Reconciliation Act of 1980 (ORA), Pub. L. 96–499, which enacted the ASC benefit in December 1980, states that this overhead amount is expected to be calculated on a prospective basis using sample survey data and similar techniques to establish reasonable estimated overhead allowances, which take into account volume (within reasonable limits), for each of the listed procedures. (H.R. Rep. No. 96–1479, at 134–35 (1980)).

To establish those reasonable estimated allowances for services furnished prior to implementation of the revised ASC payment system, section 626(b)(1) of Pub. L. 108–173 amended section 1833(i)(2)(A)(i) of the Act to require us to take into account the audited costs incurred by ASCs to perform a procedure, in accordance with a survey. Payment for ASC facility services is subject to the usual Medicare Part B deductible and coinsurance requirements and the amounts paid by Medicare must be 80 percent of the standard fee.

Section 1833(i)(1) of the Act requires us to specify, in consultation with appropriate medical organizations, surgical procedures that are appropriately performed on an inpatient basis in a hospital but that can be safely performed in an ASC and to review and update the list of ASC procedures at least every 2 years.

Section 141(b) of the Social Security Act Amendments of 1994, Pub. L. 103–432, requires us to establish a process for reviewing the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for intraocular lenses (IOLs) for a class of NTIOLs. That process was the subject of a separate final rule entitled ''Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers,'' published in the June 16, 1999 **Federal Register** (64 FR 32198). As stated earlier, in section XVII.E. of this proposed rule, we discuss the changes that we are proposing to that process.

A summary of changes to ASC payment rates made prior to CY 1998 may be found in the June 12, 1998 proposed rule (63 FR 32292). The 1998 rule proposed to rebase the ASC payment rates using cost, charge, and utilization data collected by a 1994 survey of ASCs. In that proposed rule, we also proposed to refine the ratesetting methodology that was implemented in the February 8, 1990 **Federal Register** (55 FR 4577). However, the changes that were proposed for the ratesetting methodology were not implemented because of a combination of circumstances resulting in the delayed publication of a final rule. Those circumstances included several extensions to the comment period which ended July 30, 1999, Year 2000 (Y2K) Medicare systems compliancy considerations, and legislative changes required by the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), Pub. L. 106–113 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Pub. L. 106–554. Readers may refer to the March 28, 2003 ASC List Update final rule (68 FR 15269) for a detailed discussion of these circumstances and the legislative changes.

3. Published Changes to the ASC List

Section 1833(i)(1)(A) of the Act requires the Secretary to specify surgical procedures that, although appropriately performed in an inpatient hospital setting, can also be performed safely on an ambulatory basis in an ASC, a CAH, or a hospital outpatient department. The report accompanying the legislation

explained that the Congress intended procedures currently performed on an ambulatory basis in a physician's office that do not generally require the more elaborate facilities of an ASC not be included in the list of ASC covered procedures (H.R. Rep. No. 96–1167, at 390–91, reprinted in 1980 U.S.C.C.A.N. 5526, 5753–54). In a final rule published August 5, 1982, in the **Federal Register** (47 FR 34082), we established regulations that included criteria for specifying which surgical procedures were to be included for purposes of implementing the ASC facility benefit.

Section 416.65(a) of the regulations specifies general standards for procedures on the ASC list. ASC procedures are those surgical and other medial procedures that are—

- Commonly performed on an inpatient basis but may be safely performed in an ASC;
- Not of a type that are commonly performed or that may be safely performed in physicians' offices;
- Limited to procedures requiring a dedicated operating room or suite and generally requiring a post-operative recovery room or short term (not overnight) convalescent room; and
- Not otherwise excluded from Medicare coverage.

Specific standards in § 416.65(b) limit covered ASC procedures to those that do not generally exceed 90 minutes operating time and a total of 4 hours recovery or convalescent time. If anesthesia is required, the anesthesia must be local or regional anesthesia, or general anesthesia of not more than 90 minutes duration.

Section 416.65(b)(3) of the regulations excludes from the ASC list procedures that generally result in extensive blood loss, that require major or prolonged invasion of body cavities, that directly involve major blood vessels, or that are generally emergency or life-threatening in nature.

A detailed history of published changes to the ASC list and ASC payment rates may be found in the June 12, 1998 proposed rule (63 FR 32292). Subsequently, in accordance with § 416.65(c), we published updates of the ASC list in the **Federal Register** on March 28, 2003 (68 FR 15268) and May 4, 2005 (70 FR 23690).

During years when we have not updated the ASC list in the **Federal Register**, we have revised the list to be consistent with annual calendar year changes to HCPCS and CPT codes. These annual coding updates have been implemented through program instructions to the carriers that process ASC claims. The most recent update to the list to conform with CPT and HCPCS coding changes was published in Transmittal R–720–CP, Change Request 4082, on October 21, 2005. It may be found on our Web site at: *http://www.cms.hhs.gov/Transmittals/.*

B. Proposed ASC List Update Effective for Services Furnished On or After January 1, 2007

1. Criteria for Additions to or Deletions From the ASC List

In April 1987, we adopted quantitative criteria for identifying procedures that were commonly performed either in a hospital inpatient setting or in a physician's office. Collectively, commenters responding to a notice published on February 16, 1984 in the **Federal Register** (49 FR 6023) had recommended that virtually every surgical CPT code be included on the ASC list. Consulting with other specialist physicians and medical organizations as appropriate, our medical staff reviewed the recommended additions to the list to determine which code or series of codes were appropriately performed on an ambulatory basis within the framework of the regulatory criteria in § 416.65. However, when we arrayed the proposed procedures by the site where they were most frequently performed according to our claims payment data files (1984 Part B Medicare Data (BMAD)), we found that many procedures were not commonly performed on an inpatient basis or were performed in a physician's office the majority of the time, and, thus, would not meet the standards in our regulations. Therefore, we decided that if a procedure was performed on an inpatient basis 20 percent of the time or less, or in a physician's office 50 percent of the time or more, it would be excluded from the ASC list. (April 21, 1987 (52 FR 13176)).

At the time, we believed that these utilization thresholds best reflected the legislative objectives of moving procedures from the more expensive hospital inpatient setting to the less expensive ASC setting without encouraging the migration of procedures from the generally less expensive physician's office setting to the ASC. We applied these quantitative standards not only to codes proposed for addition to the ASC list, but also to the codes that were currently on the list, to delete codes that did not meet the thresholds.

The trend towards performing surgery on an ambulatory or outpatient basis grew steadily and, by 1995, we discovered that a number of procedures that were on the ASC list at the time fell short of the 20 percent and 50 percent thresholds even though the procedures were obviously appropriate in the ASC setting. The most notable of these was cataract extraction with intraocular lens insertion that were already being performed predominately in outpatient settings by the early 1990s, although more than 20 percent were also performed as inpatient procedures. The thresholds would also have excluded from the ASC list certain newer procedures, such as CPT code 66825 (Repositioning of intraocular lens prosthesis, requiring an incision (separate procedure)), that were rarely performed on a hospital inpatient basis but that were appropriate for the ASC setting. Strict adherence to the same 20 percent and 50 percent thresholds both to add and remove procedures did not provide latitude for minor fluctuations in utilization across settings or errors that could occur in the site-of-service data drawn from the National Claims History File that we were then using for analysis.

In an effort to avoid these anomalies but still retain a relatively objective standard for determining which procedures should comprise the ASC list, we adopted in the **Federal Register** notice with comment period published on January 26, 1995 (60 FR 5185), a modified standard for deleting procedures already on the list. We deleted from the list only those procedures whose combined inpatient, hospital outpatient, and ASC site-of-service volume was less than 46 percent of the procedure's total volume and that were either performed 50 percent of the time or more in the physician's office or 10 percent of the time or less in an inpatient hospital setting. We retained the 20 percent and 50 percent standard to determine which procedures would be appropriate additions to the ASC list.

We are not proposing changes to the criteria for adding or deleting items from the ASC list effective January 1, 2007. However, please see section XVIII.B. of this proposed rule for a discussion of proposed changes in the context of developing a revised ASC payment system to be effective January 1, 2008. The proposed changes to the criteria result in the addition for CY 2008 of many procedures that do not meet the current criteria for addition to the list.

2. Response to Comments to May 4, 2005 Interim Final Rule for the ASC Update

In accordance with section 1833(i)(1) of the Act, in this proposed rule, we are proposing to update the list of procedures that are covered when furnished in an ASC, effective January

1, 2007. In the process of determining which procedures to add to the list, we focused on requests we received from the public in their comments on our May 4, 2005 interim final rule (70 FR 23690). We evaluated codes for which we received requests from the public. The public comments include requests for addition and deletion of specific procedures and for assignment to higher payment groups for specific procedures.

3. Procedures Proposed for Addition to the ASC List

Using the current criteria as described in section XVII.B.1. of this preamble, we identified 14 procedures that we are proposing to add to the ASC list effective January 1, 2007. The procedures would be assigned to one of the nine existing ASC payment groups as indicated in Table 41.

TABLE 41.—PROCEDURES PROPOSED FOR ADDITION TO THE ASC LIST EFFECTIVE JANUARY 1, 2007

CPT	Short descriptor	ASC payment group
13102	Repair wound/lesion add-on	1
13122	Repair wound/lesion add-on	1
13133	Repair wound/lesion add-on	1
19297	Place breast cath for rad	9
21356	Treat cheek bone fracture	3
22520	Percutaneous vertebroplasty, thor	9
22521	Percutaneous vertebroplasty, lumb	9
22522	Percutaneous vertebroplasty, add'l	1
35476	Repair venous blockage	9
36818	AV fuse, upper arm, cephalic	3
37205	Transcath IV stent, percutaneous	9
37206	Transcath IV stent/perc, add'l	1
43761	Reposition gastrostomy tube	1
46946	Ligation of hemorrhoids	1

4. Suggested Additions Not Accepted

There are a number of procedures for which we received requests for additions to the ASC list that we are not proposing to add to the ASC list because they do not meet the criteria set forth in section 416.65 of the CFR. Those procedures are listed in Tables 42 and 43 below. Our medical advisors believe that the procedures listed in Tables 42 and 43 may be of a type that:

- Are performed predominantly in the hospital inpatient or physician office setting;
- Require an overnight or inpatient stay;
- Require a total of 90 minutes of operating time or 4 hours or more of recovery time;
- Require major or prolonged invasion of body cavities or involve major blood vessels;
- Are generally emergent or life-threatening; or
- Are of a type that result in extensive blood loss.

We are not proposing to add 19 procedures for which we received requests for addition to the ASC list because they are procedures that are furnished predominantly in the physician office setting and according to the current criteria are not eligible for inclusion on the list. Those procedures are displayed in Table 42.

One request was made that we add CPT code 66990 (Use of ophthalmic endoscope) to the list. As we stated in our May 5, 2005 interim final rule (70 FR 23704), this code is used to recognize the use of equipment that is integral to a surgical procedure and is not a surgical procedure. For this reason, we do not believe that it is an appropriate addition to the list.

TABLE 42.—PROCEDURES NOT PROPOSED FOR ADDITION TO 2007 ASC LIST BECAUSE THEY ARE PREDOMINANTLY PERFORMED IN THE PHYSICIAN'S OFFICE

CPT	Short descriptor
31040	Exploration behind upper jaw.
45300	Proctosigmoidoscopy dx.
45303	Proctosigmoidoscopy dilate.
45330	Diagnostic sigmoidoscopy.
46221	Ligation of hemorrhoid(s).
46604	Anoscopy and dilation.
46614	Anoscopy, control bleeding.
46900	Destruction, anal lesion(s).
46910	Destruction, anal lesion(s).
46916	Destruction, anal lesion(s).
62367	Analyze spine infusion pump.
62368	Analyze spine infusion pump.
67028	Injection eye drug.
67105	Repair detached retina.
67110	Repair detached retina.
67145	Treatment of retina.
67210	Treatment of retinal lesion.
67221	Ocular photodynamic ther.
67228	Treatment of retinal lesion.

We are proposing not to add to the ASC list 14 procedures for which we received requests because our medical advisors determined that those procedures do not meet the clinical criteria (§ 416.65) for addition. That is, the procedures either require more than 4 hours of recovery time, or may result in excessive blood loss, etc., making them ineligible for addition to the list of ASC procedures. Those procedures are displayed in Table 43.

TABLE 43.—PROCEDURES NOT ADDED TO THE ASC LIST BECAUSE THEY DO NOT MEET CURRENT CLINICAL CRITERIA FOR ADDITION TO THE ASC LIST

CPT	Short descriptor
27412	Autochondrocyte implant knee.
27415	Osteochondral knee allograft.
29866	Autgrft implnt, knee w/scope.
29867	Allgrft implnt, knee w/scope.
29868	Meniscal trnspl, knee w/scpe.
35470	Repair arterial blockage.
35475	Repair arterial blockage.
47562	Laparoscopic cholecystectomy.
47563	Laparo cholecystectomy/graph.
47564	Laparo cholecystectomy/explr.
63030	Low back disk surgery.
63035	Spinal disk surgery add-on.
63042	Laminotomy, single lumbar.
63047	Removal of spinal lamina.

5. Rationale for Payment Assignment

Currently, procedures on the ASC list are assigned to one of nine payment groups based on our estimate of the costs incurred by the facility to perform the procedure. We are proposing no changes to those nine payment groups and are proposing to assign the additional procedures to one of those existing payment groups. The payment

group to which we propose each addition to the ASC list be classified is based on the payment group, which our medical advisors judged to be similar in terms of time and resource inputs to procedures currently on the list. The proposed list of procedures eligible for Medicare payment of a facility fee and the proposed rates are displayed in Addendum AA of this proposed rule. The procedures that are effected by the payment limit required by section 5103 of Pub. L. 109–171 are identified in that addendum along with their proposed rates.

6. Other Comments on the May 4, 2005 Interim Final Rule

In the May 4, 2005 interim final rule (70 FR 23690), we also invited public comments on the payment assignments for specific procedure codes that we added to the ASC list in that rule that had not been proposed for addition to the ASC list in the November 26, 2004 proposed rule (69 FR 69178). We received comments on 14 of those newly-added procedures. A summary of those comments and our proposed treatment of them for CY 2007 is discussed below.

Several comments requested that we delay adding to the ASC list CPT codes 33212 (Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular), 33213 (Insertion or replacement of pacemaker pulse generator only; dual chamber), and 33233 (Removal of permanent pacemaker pulse generator) until we implement the new ASC payment system.

We added these procedures to the ASC list in response to a request from a commenter. Our medical advisors evaluated the request and determined that these were appropriate procedures for performance in the ASC setting. We continue to believe that the procedures are appropriate for performance in the ASC and see no reason to remove them from the list at this time. Therefore, we are proposing to make no change in the ASC assignments for these three procedures.

Two commenters requested that we reassign CPT codes 57155 (Insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy) and 58346 (Insertion of Heyman capsules for clinical brachytherapy) to the highest ASC payment group. The commenters believe that payment at a higher level is necessary in order to cover the costs of the equipment and supplies used in performing the procedures.

We reviewed the OPPS cost data for these procedures and found that the median cost for CPT code 57155 is $506 and that for CPT code 58346 is $364. We do not have median cost data for the procedures performed in the ASC but the ASC payment amount for both services is $446, which is within the range of the median costs for those procedures in the generally more costly hospital outpatient setting. This leads us to believe that the $446 payment in the ASC is quite adequate. We are not proposing to assign the procedures to higher ASC payment groups.

Several commenters wrote regarding CPT codes 36475 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein); 36476 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins in single extremity, each through separate access sites); 36478 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein); and 36479 (Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites). The commenters requested that we remove these procedures from the ASC list, and suggested that if we were unwilling to remove them from the list, that we assign the procedures to a higher payment group. They believe that these procedures require significantly more facility resources than other procedures with which they are currently grouped in payment level 3. The commenters explained that if the procedures were excluded from the list, more adequate payments would be made to physicians under the Medicare physician fee schedule for the required resources.

We added these procedures to the list in response to public comments. We initially assigned the codes to ASC payment group 3, consistent with other procedures with similar clinical indications. We continue to believe that these procedures are appropriate for performance in the ASC setting and will not remove them from the list. However, we agree with the commenters' point that these procedures require significantly more facility resources than traditional vein removal procedures, and, therefore, we are proposing to reassign them to ASC payment group 9. We believe that this is an appropriate payment level that takes into consideration the costs of the required equipment and supplies.

Two comments requested that we assign CPT code 46947 (Hemorrhoidopexy by stapling) to a higher ASC payment group. The commenters stated that due to the cost of the stapler used in the procedure, the resources required for this procedure are not similar to the other surgical procedures for the treatment of hemorrhoids that are also assigned to ASC payment group 3. The commenters suggested that it would be more appropriate to assign this procedure to ASC payment group 7.

We agree with the commenters and are proposing to reassign this procedure to ASC payment group 7 for CY 2007.

One commenter raised concern about payment for CPT code 49419 (Insertion of intraperitoneal cannula or catheter, with subcutaneous reservoir, permanent). The commenter reported that the catheter that is used in performing this procedure is billed separately under the DMEPOS fee schedule, and that Medicare carriers have discretion over whether or not to allow that payment. According to the commenter, in some areas, separate payment is not made for the catheter that is integral to the procedure.

We believe that the commenter may be misinformed, because cannulas and catheters are not considered durable medical equipment, and they are not paid under the DMEPOS fee schedule. Rather, they are considered to be supplies. Payment for supplies furnished by an ASC in connection with a surgical procedure is bundled into the payment for the surgical procedure for which the supplies are required.

One commenter requested that we allow separate payment for the material used as the sling in the procedure described by CPT code 51992 (Laparoscopy, surgical; sling operation for stress incontinence (e.g., fascia or synthetic)). The commenter stated that without separate payment for the sling material, the Medicare payment for performing the procedure is inadequate to cover the service. The commenter also stated that there is no specific HCPCS code to use for billing the synthetic sling material.

We added CPT code 51992 to the ASC list in the last update in response to comments. We assigned CPT code 51992 to ASC payment group 5, the same ASC payment group to which other procedures to treat stress incontinence are assigned. We realize that the synthetic material for the sling may be costly, but there is no identifiable HCPCS code available for use in ASCs to report the material, and such material is not eligible for separate payment from Medicare in the ASC or

in any other setting. Further, CPT code 51992 describes a procedure that may be performed using synthetic material or fascia. As such, we cannot know whether the more costly synthetic material is used in any specific procedure and do not believe it is appropriate to fully incorporate the synthetic supply costs into the payment for all of the procedures performed. We continue to believe that ASC payment group 5 is an appropriate assignment for the procedure, and we are not proposing to change that assignment.

One commenter requested that we make separate payment for the microinserts that are used in performing CPT code 58565 (Hysteroscopy, surgical; with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants) even though there is no specific HCPCS code to describe the microinserts for billing, making separate payment impossible.

We added CPT code 58565 to the ASC list in the last update in response to public comment. We assigned the procedure to ASC payment group 4 with other procedures with similar clinical indications. After further review, we are convinced that the procedure described by CPT code 58565 is significantly more resource-intensive than the other procedures in ASC payment group 4 and, therefore, we are proposing to reassign it to ASC payment group 9 for CY 2007.

Several comments requested that CMS issue instructions to permit separate payment for the catheters that are inserted during the procedures described by CPT codes 19296 (Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy) and 19298 (Placement of radiotherapy afterloading brachytherapy catheters into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance).

One commenter supported adding CPT code 19296 to the ASC list and assigning it to ASC payment group 9, but asserted that separate payment should also be provided for the balloon catheter inserted during the procedure. With regard to CPT code 19298, other commenters also stated that the payment level is inadequate and that separate payment should be allowed for the catheters inserted during the procedure. One of the commenters explained that the catheters used to perform the procedure described by CPT code 19298 are not high cost items (about $18.50 each) but these procedures typically use 30 catheters which makes the catheters a significant cost factor in performing the procedure.

The catheters used in these procedures are classified as surgical supplies and as such, are not included on the DMEPOS fee schedule and are, therefore, not eligible for separate payment in the ASC. Payments for the costs of the catheters are packaged into the payments for performing the procedures. Currently CPT code 19298 is assigned to ASC payment group 1. Based on the information provided by the commenters we are persuaded that reassignment to a higher ASC payment group is warranted. Therefore, we are proposing to reassign CPT code 19298 to ASC payment group 9 for CY 2007.

C. Proposed Regulatory Changes for CY 2007

As stated earlier, we are proposing a revised payment system for ASCs to be implemented effective January 1, 2008, including revisions to the ASC list for CY 2008, the ratesetting method, and the applicable ASC regulations to incorporate the requirements and payments for ASC facility services under the proposed revised ASC system. We expect that a final rule implementing the revised ASC payment system will be published separately in the spring of 2007. The revised ASC payment system will not take effect until January 1, 2008. However, we need to revise our current regulations at part 416, subparts D and E to ensure that the rules governing our current system are clearly distinguishable from those that would apply to the revised system beginning January 1, 2008. Therefore, we are proposing to revise subparts D and E to part 416 to reflect that these are the rules governing the APC payment system prior to January 1, 2008, and to redesignate the existing subpart F as subpart G under part 416 to codify the rules governing the ASC payment adjustment for NTIOLs. In addition, we are proposing to revise existing—

- § 416.1 (Basis and scope) to remove the obsolete reference to ''a hospital outpatient department,'' to add provisions of section 5103 of Pub. L. 109–171, and applicable provisions of Pub. L. 108–173.
- § 416.65 (Covered surgical procedures) to modify the introductory text to clearly denote the section's application to covered surgical procedures furnished before January 1, 2008. In addition, we are proposing to remove the obsolete cross-reference in paragraph (a)(4) to § 405.310 and replace it with the correct cross-reference to § 411.15.
- § 416.125 (ASC facility services payment rate) to incorporate the limitation on payment imposed by section 5103 of Pub. L. 109–171.
- § 488.1 (Definitions) to correct a longstanding error by adding ambulatory surgical centers to the definition of a supplier in conformance with section 1861(d) of the Act.

We also are proposing to add a new § 416.76 and § 416.121 to subparts D and E, respectively, to clearly state that the provisions of subparts D and E apply to services furnished before January 1, 2008.

D. Implementation of Section 5103 of Pub. L. 109–171 (DRA)

(If you choose to comment on issues in this section, please include the caption ''Section 5103'' at the beginning of your comments.)

As noted in section XVII.A.1. of this preamble, section 5103 of Pub. L. 109–171 requires us to substitute the OPPS payment amount for the ASC standard overhead amount for surgical procedures performed at an ASC on or after January 1, 2007, but prior to the revised payment system when the ASC standard overhead amount exceeds the OPPS payment amount for the procedure. In Addendum AA of this proposed rule, we identify the HCPCS codes that we believe would be subject to section 5103 based on a comparison of the CY 2007 proposed OPPS payment rates and the ASC standard overhead amounts that are effective in CY 2007. We are proposing to add paragraph (c) to § 416.125 to reflect this change.

E. Proposal To Modify the Current ASC Process for Adjusting Payment for New Technology Intraocular Lenses (NTIOLs)

1. Background

(If you choose to comment on issues in this section, please include the caption ''NTIOL'' at the beginning of your comments.)

At the inception of the ASC benefit on September 7, 1982, Medicare paid 80 percent of the reasonable charge for IOLs supplied for insertion concurrent with or following cataract surgery performed in an ASC (see 47 FR 34082, August 5, 1982). Section 4063(b) of OBRA 1987, Pub. L. 100–203, amended the Act to mandate that we include payment for an IOL furnished by an ASC for insertion during or following cataract surgery as part of the ASC facility fee for insertion of the IOL, and that the facility fee include payment that is reasonable and related to the cost of acquiring the class of lens involved in the procedure.

Section 4151(c)(3) of the Omnibus Budget Reconciliation Act of 1990

(OBRA 1990), Pub. L. 101–508, froze the IOL payment amount at $200 for IOLs furnished by ASCs in conjunction with surgery performed during the period beginning November 5, 1990, and ending December 31, 1992. We continued paying an IOL allowance of $200 from January 1, 1993, through December 31, 1993.

Section 13533 of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), Pub. L. 103–66, mandated that payment for an IOL furnished by an ASC be equal to $150 beginning January 1, 1994, through December 31, 1998.

Section 141(b)(1) of the Social Security Act Amendments of 1994 (SSAA 1994), Pub. L. 103–432, required us to develop and implement a process under which interested parties may request a review of the appropriateness of the payment amount for insertion of an IOL, to ensure that the facility fee for the procedure includes payment that is reasonable and related to the cost of acquiring a lens that belongs to a class of NTIOLs.

In the February 8, 1990 **Federal Register** (55 FR 4526), we published a final notice entitled ''Revision of Ambulatory Surgery Center Payment Rate Methodology,'' which implemented Medicare payment for an IOL furnished at an ASC as part of the ASC facility fee for insertion of the IOL.

In the June 16, 1999 **Federal Register** (64 FR 32198), we published a final rule entitled ''Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers'' to add a subpart F (§§ 416.180 through 416.200) to 42 CFR Part 416, which established a process for adjusting payment amounts for insertion of a class of NTIOLs furnished by ASCs.

Our current regulations §§ 416.180 through 416.200 define the terms relevant to the process, establish the payment review process, and establish $50 as the payment adjustment amount that is added to the ASC facility fee for insertion of a lens that CMS determines is an NTIOL. Section 416.200 provides that the payment adjustment applies for a 5-year period that begins when we recognize the first lens that establishes a class of NTIOLs. In accordance with § 416.200(b), insertion of a lens that we subsequently recognize as belonging to an existing NTIOL class would receive the payment adjustment for the remainder of the 5-year period established for the class. Section 416.185(f)(2) provides that after July 16, 2002, we have the option of changing the $50 adjustment amount through proposed and final rulemaking in connection with ASC services.

Since June 16, 1999, we have issued a series of **Federal Register** notices to list lenses for which we received requests for a NTIOL payment adjustment and to solicit comments on those requests, or to announce the lenses that we have determined meet the criteria and definition of NTIOLs. We last published a **Federal Register** notice pertaining to NTIOLs on April 28, 2006 (71 FR 25176).

a. Current ASC Payment for Insertion of IOLs

The current ASC payment groups, payment rates and procedural HCPCS codes for cataract extraction with IOL insertion are as follows:

Payment Group 6—$826 ($676 + $150 IOL Allowance)

- CPT code 66985, Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
- CPT code 66986, Exchange of intraocular lens

Payment Group 8—$973 ($823 + $150 IOL allowance)

- CPT code 66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (for example, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (for example, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage
- CPT code 66983 Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one stage procedure)
- CPT code 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (for example, irrigation and aspiration or phacoemulsification)

b. Classes of NTIOLs Approved for Payment Adjustment

Since implementation of the process for adjustment of payment amounts for NTIOLs, that was established in the June 16, 1999 **Federal Register**, we have approved three classes of NTIOLs, as shown in the following table:

NTIOL category	HCPCS code	$50 approved for services furnished on or after	NTIOL characteristic	IOLs eligible for adjustment
1	Q1001	May 18, 2000, through May 18, 2005.	Multifocal	Allergan AMO Array Multifocal lens, model SA40N.
2	Q1002	May 18, 2000, through May 18, 2005.	Reduction in Preexisting Astigmatism.	STAAR Surgical Elastic Ultraviolet-Absorbing Silicone Posterior Chamber IOL with Toric Optic, models AA4203T, AA4203TF, and AA4203TL.
3	Q1003	February 27, 2006, through February 26, 2011.	Reduced Spherical Aberration.	Advanced Medical Optics (AMO) Tecnis(®) IOL models Z9000, Z9001, and ZA9003; Alcon Acrysof IQ Model SN60WF.

2. Proposed Changes

a. Process for Recognizing IOLs as Belonging to an Active NTIOL Class

Currently, we accept and review applications for inclusion in an active NTIOL class on a continuous basis throughout the year in accordance with §§ 416.180 through 416.200 of the regulations. We are proposing to continue this established process and to update and streamline it, as discussed below, to specify the request and comment review process, the information that a request must include to be accepted for review, the specific factors to be considered in evaluating requests, and the process to provide notification of determinations. As stated in section XVII.D. of this preamble, we are proposing to redesignate existing subpart F of part 416 as subpart G, which would include the regulations pertaining to the ASC payment adjustment for NTIOLs. In addition, we are proposing to revise redesignated subpart G to add new § 416.180, § 416.185, § 416.190, § 416.195, and § 416.200 to the regulations to reflect the changes that we are proposing to this process.

One of the regulatory changes that we are proposing is to revise existing § 416.180 to establish the basis and

scope for this ASC payment adjustment. This proposal would eliminate the definitions currently included in that section for ''Class of new technology intraocular lenses (IOLs),'' ''Interested party,'' ''New technology IOL,'' and ''New technology subset.'' We do not believe that we need to retain these definitions because additional revisions that we are proposing to the regulations at part 416 would eliminate the term ''interested party'' from §§ 416.185(c) and 416.190 and the term ''new technology subset'' from §§ 416.185(g), 416.200(a), (b), and (c) and further clarify the terms ''new technology IOL'' and ''class of new technology intraocular lenses (IOLs).''

The other changes that we are proposing to part 416, pertaining to the ASC payment adjustment for NTIOLs, are discussed in this section.

b. Public Notice and Comment Regarding Adjustments of NTIOL Payment Amounts

We are proposing to update and streamline the process for determining whether an IOL that is to be inserted during or subsequent to cataract extraction qualifies for payment adjustment as a NTIOL, as set forth in existing § 416.185 of our regulations. The basis for the current NTIOL payment review process was enacted in 1994 and has been implemented through a series of separate **Federal Register** notices specific to NTIOLs. We are proposing to modify the current process of using separate **Federal Register** notices to notify the public of requests to review lenses for membership in new NTIOL classes, to solicit public comment on requests, and to notify the public of CMS determinations concerning new classes of NTIOLs for which an ASC payment adjustment would be made. We are proposing that these NTIOL-related notifications would be fully integrated into the annual notice and comment rulemaking for updating the ASC payment rates, the specific payment system in which NTIOL payment adjustments are made. Given that the NTIOL payment adjustments are applicable to ASC services and that the proposal for updating the new ASC payment system to be implemented in January 2008 anticipates an annual update process in coordination with notice and comment rulemaking on the OPPS, aligning the NTIOL process with this annual update would promote coordination and efficiency, thereby streamlining and expediting the NTIOL notification, comment, and review process.

Specifically, we are proposing the following process:

- We would announce annually in the **Federal Register** document that proposes the update of ASC payment rates for the following calendar year, a list of all requests to establish new NTIOL classes accepted for review during the calendar year in which the proposal is published and the deadline for submission of public comments regarding those requests. The deadline would be 30 days following publication of the list of requests.
- In the **Federal Register** document that finalizes the update of ASC payment rates for the following calendar year we would—
  + Provide a list of determinations made as a result of our review of all requests and public comments; and
  + Publish the deadline for submitting requests for review in the following calendar year.

We believe that the coordination of public notice and comment regarding requests to establish new NTIOL classes with the update of ASC payment rates would facilitate judicious and comprehensive review and comment by interested parties, thereby resulting in more timely access to improved health technologies for Medicare beneficiaries. Accordingly, we are proposing to revise § 416.185 to reflect these proposed changes to the current process for publishing separate **Federal Register** notices specific to NTIOLs.

We note that we did not receive any review requests in response to the specific NTIOL April 28, 2006 notice (71 FR 25176) soliciting CY 2006 requests for review of the appropriateness of the payment amount for particular NTIOLs furnished in ASCs.

c. Factors CMS Considers in Determining Whether an Adjustment of Payment for Insertion of a New Class of NTIOL Is Appropriate

In determining whether a lens belongs to a new class of NTIOLs for which the ASC payment amount for insertion 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. We are proposing to base our determinations on consideration of the following factors:

- The IOL must have been approved by the FDA and claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison with currently available IOLs must have been approved by the FDA for use in labeling and advertising.
- The IOL is not described by an active or expired NTIOL class; that is, it does not share the predominant, class-defining characteristic associated with improved clinical outcomes with designated members of an active or expired NTIOL class.
- Evidence demonstrating that use of the IOL results in measurable, clinically meaningful, improved outcomes in comparison with use of currently available IOLs. According to the statute, and consistent with previous examples provided by CMS, superior outcomes that would be considered include the following:
  + Reduced risk of intraoperative or postoperative complication or trauma;
  + Accelerated postoperative recovery;
  + Reduced induced astigmatism;
  + Improved postoperative visual acuity;
  + More stable postoperative vision;
  + Other comparable clinical advantages, such as—
    ++ Reduced dependence on other eyewear (for example, spectacles, contact lenses, and reading glasses)
    ++ Decreased rate of subsequent diagnostic or therapeutic interventions, such as the need for YAG laser treatment.
    ++ Decreased incidence of subsequent IOL exchange.
    ++ Decreased blurred vision, glare, other quantifiable symptom or vision deficiency.

In order to assess the clinical performance of a candidate IOL to establish a new NTIOL class, outcomes from use of the candidate lens would be compared with outcomes of use of currently available IOLs. Due to the rapid evolution of medical technology, we expect that the baseline of currently available IOLs for comparison would change from year to year. It is our expectation that the current ASC payment adjustment for active NTIOL classes should support the development and dissemination of new IOL technologies that would continue to improve the clinical outcomes of Medicare beneficiaries furnished IOLs after cataract extraction.

Accordingly, we are proposing to revise our process for determining whether a lens belongs to a new class of NTIOLs for which an ASC payment adjustment is appropriate by setting forth the factors that we propose to

consider in making this determination. In addition, we are proposing to revise § 416.195 of the regulations to incorporate these proposed factors.

Further, we are seeking public comments on the desirability of further interpreting the phrase ''currently available lenses'' for purposes of comparison and specific approaches to providing such clarifications. We believe that further interpretation could be helpful to requestors seeking to provide the most relevant, authoritative evidence concerning the clinical benefits of their lenses in comparison with those currently available lenses and to us as we review the information provided in requests to establish new NTIOL classes. However, we also believe that any clarifications should incorporate our expectations for technological progression of the baseline comparison lenses over time as we make future annual determinations regarding the establishment of new NTIOL classes. Therefore, we believe that the public's comments regarding practical and meaningful approaches to elaborating on the phrase ''currently available lenses'' would facilitate both requestors' submission of complete requests for review and appropriate determinations by CMS regarding new NTIOL classes to receive the ASC payment adjustment.

d. Proposal To Revise Content of a Request To Review

To enable us to make a determination that the criteria for a payment adjustment for a new NTIOL class are met, we are proposing to require that a request include the information listed below. We are proposing to revise the content of a request (as currently set forth in § 416.195(a)) based on our experience in evaluating applications for OPPS pass-through status for new device categories over the past 6 years. We have found that the additional information allows our medical advisors to complete a more comprehensive evaluation, which would ensure that a payment adjustment is appropriate. We also have found that such information must be updated in a timely manner to ensure its relevancy to advancing technologies. Therefore, we also are proposing to post the information listed below on the CMS Web site at: *http://www.cms.hhs.gov/center/asc/asp* to provide easy access for updating rather than incorporating it in § 416.195(a) of the regulations.

In addition, we are proposing to continue to require that a separate request would be required for each NTIOL for which a payment review as member of a new class is sought. We are proposing that a request that does not include all of the following information would be considered incomplete and could not be accepted for review until all information is furnished:

- Proposed name or description of a new class of NTIOLs.
- Trade/brand name, manufacturer, and model number of the IOL for which the request to establish a new NTIOL class is being made. (Applications must include the name and description of at least one marketed IOL that would be placed in the proposed new NTIOL class.)
- A list of all active or expired NTIOL classes that describe similar IOLs. For each active or expired class, provide a detailed explanation as to why that class would not describe the candidate IOL.
- Detailed description of the FDA approved clinical indications for the candidate IOL.
- Description of the IOL—
  + What is it? Provide a complete physical description of the IOL, including its components, for example, its composition; coating or covering; haptics; material; and construction.
  + What does it do?
  + How is it used?
  + What makes it different from other currently available IOLs?
  + What makes it superior to other currently available IOLs used for similar indications?
  + What are its clinical characteristics, for example, is it used for treatment of specific pathology; what is its life span; what are the complications associated with its use; and for what patient populations is it intended?
  + Submit relevant booklets, pamphlets, brochures, product catalogues, price lists, and/or package inserts that further describe and illuminate the nature of the IOL.
- If the candidate IOL replaces or improves upon an existing IOL, identify the trade/brand name and model of the existing IOL(s).
- Full discussion of the clinically meaningful, improved outcomes that result from use of the candidate IOL compared to use of other currently available IOLs. This discussion must include evidence to demonstrate that use of the IOL results in measurable, clinically significant improvement over currently available IOLs in one or more of the following areas:
  + Reduced risk of intraoperative or postoperative complication or trauma.
  + Accelerated postoperative recovery.
  + Reduced induced astigmatism.
  + Improved postoperative visual acuity;
  + More stable postoperative vision.
  + Other comparable clinical advantages, such as—
    ++ Reduced dependence on other eyewear (for example, spectacles, contact lenses, and reading glasses);
- Decreased rate of subsequent diagnostic or therapeutic interventions, such as the need for YAG laser treatment;
  ++ Decreased incidence of subsequent IOL exchange; and
  ++ Decreased blurred vision, glare or other quantifiable symptom or vision deficiency.
- Provide the following information for the IOL(s) for which a new class is proposed:
  + Dates the candidate IOL was first marketed, reporting inside the United States and outside the United States separately.
  + Dates of sale of the first unit of the IOL, reporting inside the United States and outside the United States separately.
  + Number of IOLs that have been sold up to the date of the application.
  + A copy of the FDA's original approval notification.
- A copy of the labeling claims approved by the FDA for the IOL, indicating its clinical advantages and/or the lens characteristics with clinical relevance.
- A copy of the FDA's summary of the IOL's safety and effectiveness.
- Reports of modifications made after the original FDA approval.

We strongly encourage and may give greater consideration for the submission of published, peer-reviewed literature and other materials that demonstrate substantial clinical improvement with use of the candidate IOL over use of currently available IOLs.

Proposed § 416.190(d) provides that, in order for CMS to invoke the protection allowed under Exemption 4 of the Freedom of Information Act (5 U.S.C. 552(b)(4)) and, with respect to trade secrets, the Trade Secrets Act (18 U.S.C. 1905), the requestor must clearly identify all information that is to be characterized as confidential.

For the stated reasons, we are proposing to revise § 416.190 to reflect these proposed changes to the content of a request for payment review of an IOL, to clarify when a request can be submitted and who may submit, and to also clarify the process for maintaining confidentiality of information included in a request. As stated earlier, we are not proposing to incorporate the list of proposed information required with each request in the regulations, but are proposing to post it on the CMS Web site to ensure that such information is updated in a timely manner and relevant to advancing IOL technologies. We are proposing to revise § 416.190 to

require that the content of each request for an IOL review must include all information as specified on the CMS Web for the request to be considered complete.

e. Notice of CMS Determination

We are proposing three possible outcomes from review of a request for determination of a new NTIOL class. As appropriate, for each completed request for a candidate IOL that is received by the established deadline, one of the following determinations would be announced annually in the final rule updating the ASC payment rates for the next calendar year:

- The request for a payment adjustment is approved for the IOL for 5 full years as a member of a new NTIOL class described by a new code.
- The request for a payment adjustment is approved for the IOL for the balance of time remaining as a member of an active NTIOL class.
- The request for a payment adjustment is not approved.

We also are proposing to summarize briefly in the ASC final rule the evidence that was reviewed, the public comments, and the basis for our determination. When a new NTIOL class is established, we are proposing to identify the predominant characteristic of NTIOLs in that class that sets them apart from other IOLs (including those previously approved as members of other expired or active NTIOL classes) and is associated with improved clinical outcomes. The date of implementation of a payment adjustment in the case of approval of an IOL as a member of a new NTIOL class would be set prospectively as of 30 days after publication of the ASC payment update final rule, consistent with the statutory requirement. The date of implementation of a payment adjustment in the case of approval of a lens as a member of an active NTIOL class would be set prospectively as of the publication date of the ASC payment update final rule.

f. Proposed Payment Adjustment

The current payment adjustment for a 5-year period from the implementation date of a new NTIOL class is $50. We are not proposing to revise this payment adjustment for CY 2007.

For CY 2007, we are proposing to revise § 416.200(a) through (c) to clarify how the IOL payment adjustment would be made and how an NTIOL would be paid after expiration of the payment adjustment. We also are proposing minor editorial changes to § 416.200(d).

XVIII. Proposed Revised Ambulatory Surgical Center (ASC) Payment System for Implementation January 1, 2008

A. Background

Generally, there are two primary elements in the total cost of performing a surgical procedure: the cost of the physician's professional services for performing the procedure and the cost of services furnished by the facility where the procedure is performed (for example, surgical supplies, equipment, nursing services, and overhead). The former is covered by the Medicare physician fee schedule. In 1980, a new Medicare benefit was enacted, authorizing payment of a fee to ASCs for facility services furnished in connection with performing certain surgical procedures.

The statute requires us to specify surgical procedures that are appropriately and safely performed on an ambulatory basis in an ASC. Moreover, we are to review and update the list of these procedures not less often than every 2 years, in consultation with appropriate trade and professional associations. The ASC list was limited in 1982 to approximately 100 procedures. Currently, the list consists of more than 2,500 CPT codes encompassing a cross-section of surgical services, although 150 of these codes account for more than 90 percent of the approximately 4.5 million procedures paid for each year under the ASC Part B benefit. Eye, pain management, and gastrointestinal endoscopic procedures are the highest volume ASC surgeries under the present payment system.

Medicare only allows payment to ASCs for procedures on the ASC list. Medicare pays 80 percent of the prospectively determined fee; the coinsurance rate is 20 percent for all procedures on the ASC list. In Pub. L. 108–173, the Congress mandated implementation of a revised payment system for ASC surgical services by no later than January 1, 2008. Pub. L. 108–173 sets forth several requirements for the revised payment system, but does not amend those provisions of the statute pertaining to the ASC list.

In section XVIII. of this preamble, we describe the provisions of the revised ASC payment system that we are proposing to implement, as required by Pub. L.108–173, not later than January 1, 2008. Our proposal encompasses two components: first, our proposal for establishing and maintaining the ASC list of Medicare approved procedures under the revised payment system, and second, the method we are proposing to use to set payment rates for ASC facility services furnished in association with procedures on the ASC list. We also discuss in this section regulatory changes that we are proposing to 42 CFR parts 416 and 488 to incorporate the rules governing ASC facility payments under the revised payment system that would be applicable beginning in CY 2008.

1. Provisions of Pub. L. 108–173

Section 626(a) of Pub. L. 108–173 amended section 1833(i)(2)(C) of the Act, which requires the Secretary to update ASC payment rates using the Consumer Price Index for all urban consumers (U.S. City average) (CPI-U) if the Secretary has not otherwise updated the amounts under the revised ASC payment system. As amended by Pub. L. 108–173, this section requires that if the Secretary is required to apply the CPI-U increase, the CPI-U percentage increase is to be applied on a fiscal year basis beginning with FY 1986 through FY 2005 and on a calendar year basis beginning with 2006.

Pub. L. 108–173 further amended section 1833(i)(2)(C) of the Act to require us in FY 2004, beginning April 1, 2004, to increase the ASC payment rates using the CPI-U as estimated for the 12-month period ending March 31, 2003, minus 3.0 percentage points. Pub. L. 108–173 also requires that the CPI adjustment factor equal zero percent in FY 2005, the last quarter of CY 2005, and each CY from 2006 through 2009.

Section 626(b) of Pub. L. 108–173 repeals the requirement that CMS conduct a survey of ASC costs upon which to base a standard overhead payment amount for surgical services performed in ASCs, and adds section 1833(i)(2)(D)(iii) to the Act, which requires us to implement by no earlier than January 1, 2006, and not later than January 1, 2008, a revised ASC payment system. The revised payment system under section 1833(i)(2)(D)(i) of the Act is to take into account the recommendations contained in a Report to Congress that the GAO was required to submit by January 1, 2005. Section 1833(i)(2)(D)(ii) of the Act requires that the revised ASC payment system be designed to result in the same aggregate amount of expenditures for surgical services furnished in ASCs the year the system is implemented as would be made if the new system did not apply as estimated by the Secretary. This requirement is to take into account the limitation in ASC expenditures resulting from implementation of section 5103 of Pub. L. 109–171 beginning January 1, 2007, as we describe in section XVII.A.1 of this preamble.

Section 1833(i)(2)(D)(iv) of the Act exempts the classification system, relative weights, payment amounts, and geographic adjustment factor (if any) under the revised ASC payment system from administrative and judicial review.

Section 626(c) of Pub. L. 108–173 adds a conforming amendment to section 1833(a)(1) of the Act providing that the amounts paid under the revised ASC payment system shall equal 80 percent of the lesser of the actual charge for the services or the payment amount that we determine.

2. Other Factors Considered

On August 2, 2005, we convened a listening session teleconference on revising the Medicare ASC payment system. Over 450 callers participated, including ASC staff, physicians, and representatives of industry trade associations. The listening session provided an opportunity for participants to identify the issues and concerns that they wanted us to address as we developed the revised ASC payment system.

Callers encouraged us to foster beneficiary access to ASCs by creating incentives for physicians to use ASCs. The issues raised by participants included suggestions to expand or eliminate altogether the ASC list, recommendations to model payment on the hospital OPPS, and concerns about how we would propose to treat the geographic wage index adjustment and the annual ASC payment rate update. Several callers also raised concerns about ensuring adequate payment for supplies, ancillary services, and implantable devices under the new payment system, as well as developing a process to allow special payment for new technology.

We have also met with representatives of the ASC industry over the past several years to discuss options for ratesetting other than conducting a survey, to discuss timely updates to the ASC list, and to listen to industry concerns related to the implementation of a new payment system. We appreciate the thoughtful suggestions that have been presented. We have carefully considered the concerns and issues brought to our attention, and a number of the proposals in this section for revising the ASC list and the method by which we set ASC payment rates take these concerns and issues into account. We look forward to receiving comments on the proposed changes set forth in this proposed rule and to continued input from representatives of industry associations and professional societies as we develop the final rule.

B. Procedures Proposed for Medicare Payment in ASCs Effective for Services Furnished On or After January 1, 2008

1. Proposed Payable Procedures

(If you choose to comment on issues in this section, please include the caption ''ASC Payable Procedures'' at the beginning of your comments.)

In its March 2004 Report to the Congress, MedPAC recommended replacing the current ''inclusive'' list of procedures, which are the only procedures for which Medicare allows payment of an ASC facility fee, with an ''exclusionary'' list. That is, rather than limiting payment of an ASC facility fee to a list of procedures that CMS specifies, Medicare would allow payment to an ASC facility for any surgical procedure except those that CMS explicitly excludes from payment. MedPAC further recommended that clinical safety standards and the need for an overnight stay be the only criteria for excluding a procedure from payment of an ASC facility fee. MedPAC suggested that some of the criteria, such as site-of-service volume and time limits, which we have used in the past to identify procedures for the ASC list, are probably no longer clinically relevant.

We have given careful consideration to MedPAC's recommendations and participated in considerable discussion and consultation with members of ASC trade associations and physicians who represent a variety of surgical specialties regarding the criteria that we would use to identify procedures that we would propose for payment under the new ASC payment system. We agree that adoption of a policy like that recommended by MedPAC would serve both to protect beneficiary safety and increase beneficiary access to procedures in appropriate clinical settings, recognizing the ASC industry's interest in obtaining Medicare payment for a much wider spectrum of services than is now allowed. Therefore, we are proposing that, under the revised ASC payment system for services furnished on or after January 1, 2008, Medicare would allow payment of an ASC facility fee for any surgical procedure performed at an ASC, except those surgical procedures that we determine are not payable under the ASC benefit.

Further, we are proposing to establish beneficiary safety and the need for an overnight stay as the principal clinical considerations and factors in determining whether payment of an ASC facility fee would be allowed for a particular surgical procedure. As discussed in section XVIII.B.2 below, we also are proposing to exclude from payment under the ASC revised payment system those surgical procedures that are not eligible for separate payment under the OPPS and CPT surgical unlisted procedure codes.

We discuss below the criteria that we are proposing as the basis for identifying procedures that would pose a significant safety risk to a Medicare beneficiary when performed in an ASC, or procedures following which we would expect a Medicare beneficiary to require overnight care.

a. Proposed Definition of Surgical Procedure

In order to delineate the scope of procedures that constitute ''outpatient surgical procedures,'' we must first clarify what we consider to be a ''surgical'' procedure. Under the current ASC payment system, we define as a surgical procedure any procedure described within the range of CPT Category I codes that the AMA defines as ''surgery'' (CPT codes 10000–69999) for purposes of the ASC payment system. Under the revised payment system, we are proposing to continue that standard. However, we seek comment on whether all services contained in this range are appropriately defined as ''surgery.'' For example, should procedures that are primarily office-based (see Addendum CC) or procedures that require relatively inexpensive resources to perform be excluded from the list? Within the CPT surgical code range, such procedures that either require very limited facility resources or are primarily performed in procedure rooms in physician offices could be considered not to be surgical procedures, in that they may not require typical surgical resources, such as a fully equipped operating room or significant postoperative recovery area, that are generally associated with surgical procedures that are predominantly performed in facility settings or have significant associated resource costs. Procedures that require relatively inexpensive resources to perform could be defined based on an ASC payment threshold, for example $100 or $200, such that procedures below this threshold would be excluded from the ASC list of procedures. We seek comment on what an appropriate payment threshold would be for defining procedures that require relatively inexpensive resources.

In addition, we are proposing to include within the scope of surgical procedures payable in an ASC certain services that are described by HCPCS alphanumeric codes (Level II HCPCS codes) or by CPT Category III codes which directly crosswalk to or are

clinically similar to procedures in the CPT surgical range. We are proposing to include these three types of codes in our definition of surgical procedures because they all are eligible for payment under the OPPS and, to the extent it is reasonable to do so, we are proposing that the new ASC payment system parallel the OPPS in its policies.

An example of a Level II HCPCS code that we believe represents a procedure that could be safely and appropriately performed in an ASC is HCPCS code G0297 (Insertion of single chamber pacing cardioverter defibrillator pulse generator). We developed this alphanumeric code for use in the OPPS because CPT code 33240, which describes the surgical insertion of cardioverter defibrillator pulse generators, does not distinguish insertion of a single chamber cardioverter defibrillator generator from insertion of a dual chamber cardioverter defibrillator generator. We were concerned that different facility resources could be required for the insertion of these two types of cardioverter defibrillator pulse generators, so we developed alternate codes to permit hospitals to more accurately report the resources required when these surgical procedures are performed for payment under the OPPS. In instances such as this, when an alphanumeric Level II HCPCS code is established as a substitute for a CPT surgical procedure code which does not adequately describe, from a facility perspective, the nature of a surgical service, we are proposing to allow payment for the alphanumeric code under the proposed new ASC payment system. We are proposing not to allow payment of an ASC facility fee for Level II HCPCS codes or Category III CPT codes that describe services which fall outside the scope of surgical procedures described by CPT codes 10000–69999.

We recognize that continuing to use this definition of surgery would exclude from payment of an ASC facility fee certain invasive, ''surgery-like'' procedures, such as cardiac catheterization or certain radiation treatment services which are assigned codes outside the CPT surgical range. However, we believe that continuing to rely on the CPT definition of surgery would be administratively straightforward, uncontroversial, and consistent with our proposal to allow ASC payment for all outpatient surgical procedures. Since 1987, the ASC list has consisted of CPT codes that are defined as surgery by CPT. Given the number of other changes that we expect to be implemented as part of the proposed new payment system, along with the significant expansion of the ASC list that we are proposing, we believe that it would be prudent at the outset to continue to define surgery as it is defined by the CPT code set, which is used to report services for payment under both the Medicare Physician Fee Schedule (MPFS) and the OPPS. However, we are interested in commenters' opinions regarding the appropriateness of including primarily office-based procedures or including procedures that require relatively inexpensive resources to perform on the approved list of ASC procedures and we seek comment on this issue. That said, we have reviewed thousands of CPT codes in the surgical range (CPT codes 10000 through 69999), and we are proposing to not exclude payment for more than 750 additional surgical procedures, as well as continuing to not exclude payment for the more than 2,500 CPT codes on the current ASC list. If we were to consider CPT codes in the surgical range that were predominantly office-based to not be surgical procedures for purposes of the ASC payment system, the additions to the ASC list for CY 2008 would be limited to no more than about 300 other procedures. Similarly, if we were to define procedures requiring relatively inexpensive resources to not be surgical procedures, then additions to the ASC list for ASC payment would be more limited than under our current proposal.

However, we are cognizant of the dynamic nature of ambulatory surgery, which has resulted in a dramatic shift of services from inpatient to outpatient settings over the past two decades. Therefore, we are soliciting comments regarding other services which are invasive and ''surgery-like,'' which could safely and appropriately be performed at an ASC, and which require the resources typical of an ASC, even though the procedures are described by codes that fall outside the range of CPT surgical codes. In particular, we would be interested in considering commenters' views of what constitutes a ''surgical'' procedure.

b. Procedures Proposed for Exclusion From Payment Under the Revised ASC System

As stated above, we are proposing to allow payment of an ASC facility fee for all procedures within the surgical range of CPT codes that do not pose a safety risk to Medicare beneficiaries or require an overnight stay. Having established what we would propose as constituting a ''surgical procedure,'' we next considered criteria that would enable us to identify procedures that could pose a significant safety risk when performed in an ASC or that would require an overnight stay within the bounds of prevailing medical practice. We discuss in this section how we propose to identify procedures that could pose a significant safety risk.

(1) Significant Safety Risk

First, we are proposing to exclude from payment of an ASC facility fee any procedure that is included on the current OPPS inpatient list. (See Addendum E to this proposed rule and section XII. of this preamble for a discussion of the OPPS inpatient list.) The procedures included on that list are typically performed in the inpatient hospital setting due to the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. We believe that any procedure for which we do not allow payment in the hospital outpatient setting due to safety concerns would not be safe to perform in an ASC.

Second, we are proposing to exclude from payment of an ASC facility fee procedures that the CY 2005 Part B Extract Summary System (BESS) data indicate are performed 80 percent or more of the time in the hospital inpatient setting, even if those procedures are not included on the OPPS inpatient list. (See Table 4.) We selected an 80 percent threshold because we believe that an 80 percent level of inpatient performance is a fair indicator that a procedure is most appropriately performed on an inpatient basis and as such, would pose significant safety risks for Medicare beneficiaries if performed in an ASC. We find that procedures with inpatient utilization frequencies above this proposed threshold are complex and are likely to require a longer and more intensive level of care postoperatively than what is provided in a typical ASC. We believe that performing these procedures in an ASC, where immediate access to the full resources of an acute care hospital is not the norm, would pose a significant safety risk for beneficiaries.

Third, we are proposing to retain the specific criteria for evaluating safety risks that are listed in § 416.65(b)(3). Procedures that involve major blood vessels; prolonged or extensive invasion of body cavities; extensive blood loss; or are emergent or life-threatening in nature could, by definition, pose a significant safety risk. Therefore, we are proposing to exclude from payment of an ASC facility fee, procedures that may be expected to involve any of these characteristics based on evaluation by

our medical advisors. We note that most of the procedures that our medical advisors identified as involving any of the characteristics listed currently in § 416.65(b)(3), also require overnight or inpatient stays, reinforcing their exclusion from being paid when performed in an ASC.

Finally, we are proposing not to continue applying under our proposed revised system the current time-based prescriptive criteria at § 416.65(b)(1) and (2), which exclude from the ASC list procedures that exceed 90 minutes of operating time or 4 hours of recovery time or 90 minutes of anesthesia. We believe these criteria are no longer clinically appropriate for purposes of defining a significant safety risk for surgical procedures.

In light of these proposed changes for evaluating procedures that pose a significant safety risk for beneficiaries under our proposed revised system, we believe that it would not be appropriate to apply the existing standard at § 416.65(a)(1), which states that covered surgical procedures are those that are commonly performed on an inpatient basis but may be safely performed in an ASC, because this standard is no longer relevant to prevailing medical practice in the realm of ambulatory or outpatient surgery. Similarly, we believe that it would not be appropriate to continue applying the existing standard at § 416.65(a)(2), which states that procedures performed in an ASC are not of a type that are commonly performed, or that may be performed in a physician's office. This standard is no longer relevant within the context of our proposal only to exclude from payment of an ASC facility fee under the revised payment system those surgical procedures that pose a safety risk or require an overnight stay. We would expect the types of procedures that are commonly performed or that may be performed in a physician's office to pose no significant safety risk and to require no overnight care.

Therefore, we are proposing to add new subpart F to reflect coverage, scope and payment for ASC services under the revised payment system. Included in these changes will be new § 416.166 that will reflect these changes that we are proposing to our current policy for evaluating and identifying those procedures that would pose a significant safety risk for beneficiaries and would be excluded from our list of ASC covered procedures beginning January 1, 2008. To set apart the provisions that are applicable to our current ASC payment system from those that would apply to our proposed revised system, we are proposing to revise the section headings of subparts D and E to clearly denote the provisions that would govern covered surgical procedures furnished before January 1, 2008. We also will add new §§ 416.76 and 416.121 to clearly denote the effective dates of subparts D and E.

(2) Overnight Stay

A longstanding criterion for determining which procedures are appropriate for inclusion on the ASC list has been that the procedures on the list do not require an extended recovery time. Section 416.65(a)(3) of the regulations provides that ASC procedures ''[a]re limited to those requiring a dedicated operating room (or suite), and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room.'' Under § 416.65(b)(1)(ii), we have considered procedures that require more than 4 hours recovery or convalescent time to be inappropriately performed in the ASC.

We have heard many differing opinions as to what constitutes an ''overnight'' stay, ranging from ''more than 24 hours'' to time spent in recovery after sunset. After careful deliberation and consideration of several options, we are proposing to exclude from payment of an ASC facility fee any procedure for which prevailing medical practice dictates that the beneficiary will typically be expected to require active medical monitoring and care at midnight following the procedure. Our clinical staff evaluated each procedure using available claims and physician pricing data, as well as clinical judgment, to determine which procedures would be expected to require monitoring at midnight of the day on which the surgical procedure was performed.

We are proposing to use midnight as the defining measure of an overnight stay for several reasons. First, a patient's location at midnight is a generally accepted standard for determining his or her status as a hospital inpatient or skilled nursing facility patient and as such, it seems reasonable to apply the same standard in the ASC setting. Second, overnight care is not within the scope of ASC facility services for which Medicare makes payment. The expectation is that procedures performed at an ASC are ambulatory in nature; that is, patients undergoing a procedure in an ASC will recover from anesthesia and return home on the same day that they report to the ASC for a scheduled procedure. Finally, the expected need for monitoring at midnight is a straightforward and easily understood definition of ''overnight stay.'' We are proposing to add the requirement that procedures not require an overnight stay to proposed new § 416.166.

2. Proposed Treatment of Unlisted Procedure Codes and Procedures That Are Not Paid Separately under the OPPS

(If you choose to comment on issues in this section, please include the caption ''ASC Unlisted Procedures'' at the beginning of your comment.)

Unlisted procedure CPT codes are used to report services and procedures that are not accurately described by any other, more specific CPT codes. An example of an unlisted CPT code is 33999 (Unlisted procedure, cardiac surgery). Within the surgical range of CPT codes, there are 91 such codes. None of the unlisted CPT codes in the surgical range is on the current ASC list of approved procedures. Under the OPPS, we assign unlisted CPT codes to the lowest weighted APC in the relevant clinical group regardless of the median cost for the unlisted procedure code, and we do not include the highly variable claims-based cost information for unlisted services in calculating APC median costs for purposes of establishing APC relative payment weights. Payment for unlisted CPT codes is made only at the discretion of the carrier under the MPFS.

Because of concerns about the potential for safety risks when procedures that may only be reported with CPT unlisted procedure codes are performed, we are proposing to continue excluding unlisted procedure codes from payment of an ASC facility fee. For example, when CPT code 33999 is reported on a claim, we know only that some kind of cardiac surgery was performed. We have no other information about the procedure, and we have no way of knowing whether the procedure involved major blood vessels, prolonged or extensive invasion of body cavities, extensive blood loss, or was emergent or life-threatening in nature. Therefore, because of potential safety concerns, we are proposing to continue to exclude the unlisted surgical codes from payment of an ASC facility fee under the revised payment system.

Prior to our evaluation of surgical procedure codes for their safety risk, we decided to propose that we would not make separate payment under the revised ASC payment system for CPT codes in the surgical range that are ''packaged'' under the OPPS. Packaged CPT codes under the OPPS are identified by status indicator 'N' in Addendum B of this proposed rule. We are making this proposal for three reasons. First, we would not be able to

establish an ASC payment rate for packaged surgical procedures using the same method we are proposing for all other ASC procedures because packaged surgical codes have no relative payment weights under the OPPS upon which to base an ASC payment rate. Second, because we want an ASC system that is as similar to the OPPS as possible, we believe that surgical procedures whose costs we package under the OPPS should also be packaged in the ASC system. Finally, ASCs, just like hospitals, would receive payment for these surgical procedures because their costs are already packaged into the APC relative payment weights for associated separately payable procedures, for which we are proposing to pay a derivative ASC facility fee.

3. Proposed Treatment of Office-Based Procedures

(If you choose to comment on issues in this section, please include the caption ''ASC Office-Based Procedures'' at the beginning of your comment.)

According to the general standard in § 416.65(a)(2) of the regulations, procedures that ''are commonly performed, or that may be safely performed, in physicians' offices'' are excluded from the ASC list. We are not proposing to continue to apply this provision under our revised system. Rather we are proposing to allow payment of an ASC facility fee for surgical procedures that are commonly and safely performed in the office setting. We reason that the types of procedures performed in physician offices would neither pose a significant safety risk nor require an overnight stay when performed in an ASC. However, we have concerns that allowing payment for office-based procedures under the ASC benefit may create an incentive for physicians inappropriately to convert their offices into ASCs or to move all their office surgery to an ASC. In section XVIII.C.5 below, to address this concern, we propose to limit payment for office-based procedures to help neutralize any such incentive. We also propose in new § 416.171(e) to set forth rules governing office-based procedures. We specifically invite comment regarding the effect on the Medicare program and on practice patterns for ambulatory surgery generally of our proposal to allow payment of an ASC facility fee for office-based procedures that historically have been excluded from the ASC list.

As discussed elsewhere in this proposed rule, we are proposing to limit payment for office-based procedures in an attempt to mitigate potentially inappropriate migration of services from the physician office setting to the ASC. Alternatively, we could entirely exclude office-based procedures or procedures that require relatively inexpensive resources to perform from the approved ASC list of procedures.

4. Listing of Surgical Procedures Proposed for Exclusion From Payment of an ASC Facility Fee Under the Revised Payment System

Tables 44 and 45 below, list the codes and short descriptors for surgical procedures that, in addition to the codes that comprise the inpatient list in Addendum E of this proposed rule, we are proposing to exclude from payment of an ASC facility fee for services furnished on or after January 1, 2008 because they pose a significant safety risk or require an overnight stay. We discuss in section XVIII.B.1.b.(1) above, our rationale for excluding the procedures in Table 44 from payment of an ASC facility fee.

For many of the procedures listed in Table 45, several disqualifying criteria could be applicable, such as ''requires inpatient stay'' or ''could potentially cause extensive blood loss'' or ''is emergent in nature.'' Rather than list multiple disqualifying criteria for individual codes in Table 45, we have defaulted to the one characteristic that is common to all the codes listed. That is, we believe that, at a minimum, prevailing medical practice would dictate the provision of overnight care following each of the procedures listed in Table 45. We acknowledge that we had to exercise a degree of clinical judgment in identifying procedures for which we are proposing to exclude payment of an ASC facility fee. Therefore, we are soliciting comments on the appropriateness of excluding these procedures from payment of an ASC facility fee under the revised payment system. We request that commenters who disagree with a proposed exclusion from payment of an ASC facility fee submit clinical evidence that demonstrates that the criteria we are proposing in proposed new § 416.166 of the regulations are not factors when the procedure is performed in the majority of cases, including data to support that the preponderance of Medicare beneficiaries upon whom the procedure is performed do not require overnight care or monitoring following the surgery. Simply asserting that the procedure can be safely performed in an ASC without providing corroborative evidence and data does not furnish us with sufficient information upon which to make an informed decision.

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Table 44. -- CPT Surgical Procedures Proposed for Exclusion from Payment of an ASC Facility Fee Because At Least 80 Percent of Medicare Cases Are Performed on an Inpatient Basis

HCPCS	Short Descriptor
20100	Explore wound, neck
21195	Reconst lwr jaw w/o fixation
21408	Treat eye socket fracture
22612	Lumbar spine fusion
22614	Spine fusion, extra segment
22899	Spine surgery procedure
23470	Reconstruct shoulder joint
24150	Extensive humerus surgery
24151	Extensive humerus surgery
27216	Treat pelvic ring fracture
27235	Treat thigh fracture
27446	Revision of knee joint
31600	Incision of windpipe
31610	Incision of windpipe
32005	Treat lung lining chemically
32020	Insertion of chest tube
32201	Drain, percut, lung lesion
32601	Thoracoscopy, diagnostic
32602	Thoracoscopy, diagnostic
32603	Thoracoscopy, diagnostic
32604	Thoracoscopy, diagnostic
32605	Thoracoscopy, diagnostic
32606	Thoracoscopy, diagnostic
33207	Insertion of heart pacemaker
33208	Insertion of heart pacemaker
33210	Insertion of heart electrode
33211	Insertion of heart electrode
33235	Removal pacemaker electrode
33244	Remove eltrd, transven
34101	Removal of artery clot
34111	Removal of arm artery clot
34201	Removal of artery clot
34203	Removal of leg artery clot
34421	Removal of vein clot
34471	Removal of vein clot
35201	Repair blood vessel lesion
35226	Repair blood vessel lesion
35231	Repair blood vessel lesion
35256	Repair blood vessel lesion
35261	Repair blood vessel lesion
35286	Repair blood vessel lesion
35459	Repair arterial blockage
35485	Atherectomy, open
35491	Atherectomy, percutaneous
35500	Harvest vein for bypass
35685	Bypass graft patency/patch
35686	Bypass graft/av fist patency
35860	Explore limb vessels
35879	Revise graft w/vein
35881	Revise graft w/vein
36597	Reposition venous catheter
37207	Transcath iv stent, open
37208	Transcath iv stent/open addl

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HCPCS	Short Descriptor
37209	Change iv cath at thromb tx
37501	Vascular endoscopy procedure
37565	Ligation of neck vein
37600	Ligation of neck artery
37605	Ligation of neck artery
37620	Revision of major vein
38120	Laparoscopy, splenectomy
38240	Bone marrow/stem transplant
42227	Lengthening of palate
43289	Laparoscope proc, esoph
43651	Laparoscopy, vagus nerve
43752	Nasal/orogastric w/stent
43830	Place gastrostomy tube
43831	Place gastrostomy tube
44206	Lap part colectomy w/stoma
44207	L colectomy/coloproctostomy
44208	L colectomy/coloproctostomy
44238	Laparoscope proc, intestine
44500	Intro, gastrointestinal tube
44901	Drain app abscess, percut
44979	Laparoscope proc, app
47370	Laparo ablate liver tumor rf
47371	Laparo ablate liver cryosurg
47490	Incision of gallbladder
49021	Drain abdominal abscess
49041	Drain, percut, abdom abscess
49061	Drain, percut, retroper absc
49200	Removal of abdominal lesion
49323	Laparo drain lymphocele
49492	Rpr ing hern premie, blocked
50542	Laparo ablate renal mass
50543	Laparo partial nephrectomy
50544	Laparoscopy, pyeloplasty
50549	Laparoscope proc, renal
54692	Laparoscopy, orchiopexy
56805	Repair clitoris
57109	Vaginectomy partial w/nodes
57284	Repair paravaginal defect
57555	Remove cervix/repair vagina
58770	Create new tubal opening
58823	Drain pelvic abscess, percut
58925	Removal of ovarian cyst(s)

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HCPCS	Short Descriptor
59030	Fetal scalp blood sample
59074	Fetal fluid drainage w/us
59409	Obstetrical care
59414	Deliver placenta
59612	Vbac delivery only
60659	Laparo proc, endocrine
62160	Neuroendoscopy add-on
62351	Implant spinal canal cath
63001	Removal of spinal lamina
63003	Removal of spinal lamina
63005	Removal of spinal lamina
63011	Removal of spinal lamina
63012	Removal of spinal lamina
63015	Removal of spinal lamina
63016	Removal of spinal lamina
63017	Removal of spinal lamina
63020	Neck spine disk surgery
63030	Low back disk surgery
63035	Spinal disk surgery add-on
63040	Laminotomy, single cervical
63042	Laminotomy, single lumbar
63045	Removal of spinal lamina
63046	Removal of spinal lamina
63047	Removal of spinal lamina
63048	Remove spinal lamina add-on
63055	Decompress spinal cord
63056	Decompress spinal cord
63057	Decompress spine cord add-on
63064	Decompress spinal cord
63066	Decompress spine cord add-on
63075	Neck spine disk surgery
63741	Install spinal shunt
64446	N blk inj, sciatic, cont inf
64447	N block inj fem, single
64448	N block inj fem, cont inf
64449	N block inj, lumbar plexus
69725	Release facial nerve
69955	Release facial nerve
69960	Release inner ear canal

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Table 45. -- CPT Surgical Procedure Codes Proposed for Exclusion from ASC Facility Fee Payment Because They Require an Overnight Stay

HCPCS/CPT Code	Short Descriptor
15170	Cell graft trunk/arms/legs
15171	Cell graft t/arm/leg add-on
15175	Acellular graft, f/n/hf/g
15176	Acell graft, f/n/hf/g add-on
15842	Flap for face nerve palsy
19240	Removal of breast
19260	Removal of chest wall lesion
20101	Explore wound, chest
20102	Explore wound, abdomen
20950	Fluid pressure, muscle
21049	Excis uppr jaw cyst w/repair
21175	Reconstruct orbit/forehead
21261	Revise eye sockets
21263	Revise eye sockets
21470	Treat lower jaw fracture
21742	Repair stern/nuss w/o scope
21743	Repair sternum/nuss w/scope
22100	Remove part of neck vertebra
22101	Remove part, thorax vertebra
22222	Revision of thorax spine
24935	Revision of amputation
25170	Extensive forearm surgery
26037	Decompress fingers/hand
27096	Inject sacroiliac joint
27220	Treat hip socket fracture
27412	Autochondrocyte implant knee
27415	Osteochondral knee allograft
27440	Revision of knee joint
27475	Surgery to stop leg growth
27524	Treat kneecap fracture
28360	Reconstruct cleft foot
29000	Application of body cast
29046	Application of body cast
29866	Autogrft implnt, knee w/scope
29867	Allgrft implnt, knee w/scope
29868	Meniscal trnspl, knee w/scope
31040	Exploration behind upper jaw
31293	Nasal/sinus endoscopy, surg

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HCPCS/CPT Code	Short Descriptor
31294	Nasal/sinus endoscopy, surg
31500	Insert emergency airway
31601	Incision of windpipe
31785	Remove windpipe lesion
34490	Removal of vein clot
34501	Repair valve, femoral vein
34510	Transposition of vein valve
34520	Cross-over vein graft
34530	Leg vein fusion
35011	Repair defect of artery
35180	Repair blood vessel lesion
35184	Repair blood vessel lesion
35190	Repair blood vessel lesion
35206	Repair blood vessel lesion
35236	Repair blood vessel lesion
35266	Repair blood vessel lesion
35321	Rechanneling of artery
35458	Repair arterial blockage
35460	Repair venous blockage
35470	Repair arterial blockage
35471	Repair arterial blockage
35472	Repair arterial blockage
35475	Repair arterial blockage
35484	Atherectomy, open
35490	Atherectomy, percutaneous
35493	Atherectomy, percutaneous
35494	Atherectomy, percutaneous
35495	Atherectomy, percutaneous
35903	Excision, graft, extremity
36455	Bl exchange/transfuse non-nb
36460	Transfusion service, fetal
36838	Dist revas ligation, hemo
37183	Remove hepatic shunt (tips)
37195	Thrombolytic therapy, stroke
37201	Transcatheter therapy infuse
37202	Transcatheter therapy infuse
37204	Transcatheter occlusion
37206	Transcath iv stent/perc addl
37606	Ligation of neck artery
37615	Ligation of neck artery
38720	Removal of lymph nodes, neck

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HCPCS/CPT Code	Short Descriptor
39400	Visualization of chest
42225	Reconstruct cleft palate
42842	Extensive surgery of throat
42844	Extensive surgery of throat
43020	Incision of esophagus
43130	Removal of esophagus pouch
43280	Laparoscopy, fundoplasty
43510	Surgical opening of stomach
43652	Laparoscopy, vagus nerve
44180	Lap, enterolysis
44186	Lap, jejunostomy
44213	Lap, mobil splenic fl add-on
44970	Laparoscopy, appendectomy
45541	Correct rectal prolapse
47011	Percut drain, liver lesion
47562	Laparoscopic cholecystectomy
47563	Laparo cholecystectomy/graph
47564	Laparo cholecystectomy/explr
47564	Laparo cholecystectomy/explr
48511	Drain pancreatic pseudocyst
49491	Rpr hern preemie reduc
50020	Renal abscess, open drain
50021	Renal abscess, percut drain
50080	Removal of kidney stone
50081	Removal of kidney stone
50541	Laparo ablate renal cyst
50945	Laparoscopy ureterolithotomy
51990	Laparo urethral suspension
53500	Urethrlys, transvag w/ scope
57106	Remove vagina wall, partial
57107	Remove vagina tissue, part
57120	Closure of vagina
57267	Insert mesh/pelvic flr addon
57295	Change vaginal graft
57310	Repair urethrovaginal lesion
57330	Repair bladder-vagina lesion
57425	Laparoscopy, surg, colpopexy
58553	Laparo-vag hyst, complex
58554	Laparo-vag hyst w/t/o, compl
58920	Partial removal of ovary(s)
60210	Partial thyroid excision

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HCPCS/CPT Code	Short Descriptor
60212	Partial thyroid excision
60220	Partial removal of thyroid
60225	Partial removal of thyroid
60240	Removal of thyroid
60252	Removal of thyroid
60260	Repeat thyroid surgery
60500	Explore parathyroid glands
60512	Autotransplant parathyroid
61623	Endovasc tempory vessel occl
61626	Transcath occlusion, non-cns
63030	Low back disk surgery
63035	Spinal disk surgery add-on
63042	Laminotomy, single lumbar
63047	Removal of spinal lamina
63048	Remove spinal lamina add-on

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C. Proposed Ratesetting Method

1. Overview of Current ASC Payment System

(If you choose to comment on issues in this section, please include the caption ''ASC Ratesetting'' at the beginning of your comment.)

The current ASC payment system consists of 9 standard overhead amounts ranging from $333 to $1339, based on data collected in a 1986 survey of ASC costs. An ASC payment ''group'' currently consists of all the procedures assigned to a particular standard overhead amount. ASC payment groups are heterogeneous in terms of clinical characteristics, cutting across all body systems and types of surgery. Medicare pays a $150 allowance for IOLs that are inserted during or subsequent to cataract surgery and an additional $50 for IOLs that we approved as NTIOLs. Medicare also makes separate payment for implantable prosthetic devices and implantable durable medical equipment surgically inserted at an ASC. Payment for all other facility services that are directly related to performing a surgical procedure is packaged into the prospectively determined ASC facility fee.

The statute requires that ASC facility services amount be increased by the CPI–U in years when the amounts are not updated. However, since 1990, the Congress has frozen or reduced the update adjustment for periods of varying duration. ASC payment rates are currently frozen at their FY 2003 level.

Carriers account for geographic wage variations when calculating individual ASC payments by applying the hospital IPPS wage index value established for the county in which the ASC is located to 34.45 percent of the national ASC standard overhead amount. The 1986 survey data are the basis for attributing 34.45 percent of ASC overhead costs to labor-related expenses. Medicare pays 80 percent of the standard overhead amount; the beneficiary coinsurance rate is 20 percent for all procedures on the list of Medicare approved ASC procedures.

The standard overhead amounts for procedures on the ASC list were last rebased in 1990 using data collected in a 1986 survey of ASC costs. The process and methodology that we used to establish the current payment system are explained in the February 8, 1990 **Federal Register** (55 FR 4526). In the June 12, 1998 **Federal Register**, we issued a proposed rule to revise the ASC payment rates and ratesetting methodology based on data collected in a 1994 survey of ASC costs (63 FR 32290). In that proposed rule, we also proposed to expand the ASC list and establish payment groups similar to those being considered for the hospital OPPS, which was under development at the time, but which was not implemented until August 2000. Although we never implemented the revised ASC payment rates and ratesetting methodology proposed in 1998, we did make final some of the 1998 proposed additions to the ASC list in the March 28, 2003 final rule with comment period (68 FR 15268). In that rule, we explained in detail why we did not implement the ratesetting methodology and payment amounts proposed in the June 12, 1998 proposed rule.

The ASC payment system that we are proposing in this proposed rule would implement requirements set forth in section 626 of Pub. L. 108–173. The revised payment system mandated by section 626(d) of Pub. L. 108–173 requires us to take into account recommendations in a report to Congress prepared by the GAO. The GAO recommendations are to be based on its study of the comparative relative costs of procedures furnished in ASCs and procedures furnished in hospital outpatient departments paid under the OPPS, and the extent to which the APCs reflect procedures performed in ASCs. Although the statutory due date for this report is January 1, 2005, CMS has not yet received the report or recommendations from the GAO. We are moving forward with our proposal for a revised ASC payment system without the benefit of GAO's recommendations because we are concerned that further delay would not give the public sufficient opportunity to review and comment on our proposed methodology, and the ASC industry and CMS would not have adequate time to prepare for changes scheduled for implementation January 1, 2008.

2. Proposal to Base ASC Relative Payment Weights on APC Groups and Relative Payment Weights Established Under the OPPS

We considered several strategies and methodologies for setting ASC payment rates under a revised payment system. We could require ASCs to submit modified cost reports as a basis for establishing ASC costs. We could simply expand the number and payment range of the current ASC payment groups. We could base payments to ASCs on the relative weights for surgical services established under the MPFS. We could base payments to ASCs on the relative weights for surgical services established under the Medicare OPPS, as suggested in Pub. L. 108–173. We could base payments to ASCs on a flat percentage of the payment for the same services established under the OPPS, as advocated by representatives of several ASC associations.

After carefully reviewing the advantages and disadvantages of each of these approaches, we are proposing, within the parameters of section 626 of Pub. L. 108–173, to use the APC groups and the relative payment weights for surgical procedures established under the OPPS as the basis of the payment groups and the relative payment weights for surgical procedures performed at ASCs. These payment weights would be multiplied by an ASC conversion factor in order to calculate the ASC payment rates. Several factors persuaded us to advance this proposal over the other approaches that we considered.

First, in section 626(d) of Pub. L. 108–173, the Congress explicitly targets the OPPS for consideration by the GAO in its study of ASC payments. We believe it is reasonable to assume that Congress, by so doing, was highlighting the relative payment weights under the OPPS as a theoretical model for ASC relative payment weights under the revised payment system. Second, the ASC benefit provides payment for facility services associated with performing surgical procedures. The OPPS has equipped us with nearly a decade of experience in developing and refining a relative payment system for facility services furnished in connection with outpatient surgical procedures.

Third, Pub. L. 108–173 applies for the first time a budget neutrality requirement to the ASC benefit. That is, in the year the revised system is implemented, the system is to be designed to result in the same aggregate amount of expenditures that would be made if the revised payment system were not implemented. Because the OPPS is also a prospective payment system for facility services that is subject to budget neutrality requirements, it provides useful parallels for a ratesetting methodology based on relative facility payment weights for surgical services under the revised ASC payment system.

Fourth, in our analysis of the APC groups to which surgical procedures are assigned for payment under the OPPS, we found a significant overlap between surgical procedures furnished in the hospital outpatient setting and those performed in ASCs. Currently, of the 150 highest volume surgical procedures furnished in hospital outpatient departments, more than half (80) are also among the 150 highest volume procedures performed in ASCs.

Finally, the ASC industry in numerous meetings with us over the past several years has frequently voiced its preference for a payment system that parallels the OPPS for the sake of promoting transparency across sites of service in the arena of outpatient surgery and to streamline and modernize how Medicare sets payments and determines what is payable under the ASC benefit.

As we explain in sections I through XVI of this proposed rule, the OPPS payment rates are based on relative payment weights which are updated annually. APCs to which surgical procedures are assigned are generally homogeneous both in terms of clinical characteristics and resource requirements. The APCs have been continually refined over the past 6 years through the work of the APC Panel and as a result of comments received during the OPPS annual rulemaking cycles.

Moreover, we believe that the APC groups and the relativity in resource utilization among APCs containing surgical procedures have matured so that they are reasonable and appropriate models for grouping outpatient surgical procedures and determining the relativity in the ASC payment weights in terms of clinical and resource homogeneity. For example, whether performed in a hospital outpatient department or in an ASC, we believe the time and facility resources required to perform a routine laparoscopic hernia repair (CY 2006 OPPS relative payment weight of 43.0498) are approximately 4 times higher than those required to perform a diagnostic colonoscopy (CY 2006 OPPS relative payment weight of 8.5588). Thus, we believe that the relative payment weights established under the OPPS for procedures performed in the outpatient hospital setting reasonably reflect the relative resources required for such procedures and do so with sufficient coherence to be applicable to other ambulatory sites of service. Taking all these factors into account, we are proposing to use the APCs as a ''grouper'' and the APC relative payment weights as the basis for ASC relative payment weights and for calculating ASC payment rates under the revised payment system. Accordingly, we are proposing to establish provisions in proposed new subpart F §§ 416.167, 416.169, and 416.171 to reflect these proposed changes for calculating the ASC payment rates beginning January 1, 2008.

In the following sections, we focus on several additional basic assumptions that affect how we are proposing to calculate the ASC payment rates for implementation in January 2008.

3. Proposed Packaging Policy

(If you choose to comment on issues in this section, please include the caption ''ASC Packaging'' at the beginning of your comment.)

Payment for a surgical procedure under both the current OPPS and ASC payment systems represents payment for a package of various items and services, all of which are directly related and required in order to perform the procedure. In both systems, we package into a single facility fee the payment for a bundle of direct and indirect costs incurred by the facility to perform the procedure. These costs include, but are not limited to, use of the facility, including an operating suite or procedure room and recovery room; nursing, technician, and related services; administrative, recordkeeping and housekeeping items and services; medical and surgical supplies and equipment; surgical dressings; and materials for anesthesia.

Medicare currently applies different rules under the ASC payment system and the OPPS system for determining whether payment for other items and services directly related to a surgical procedure is packaged into the facility payment for the associated surgical procedure or paid for separately. These other items and services include drugs, biologicals, contrast agents, implantable devices, and diagnostic services such as imaging. Currently, Medicare packages payment for the costs for all drugs, biologicals, and diagnostic services, including imaging, into the ASC standard overhead amount for the surgical procedure with which these items and services are associated. Under the OPPS, Medicare pays separately for some of these items and services, in addition to paying for the surgical procedure.

ASCs currently receive separate payment for prosthetic implants and implantable durable medical equipment (DME). Conversely, under the OPPS, payment for prosthetic implants and implantable DME is packaged into the facility fee for the surgical procedure performed to insert the implants. Payment for IOLs and implantable surgical supplies, such as stents, mesh, guide wires, pins, and catheters is packaged into the associated surgical facility fee under both the OPPS and the ASC payment systems. We considered several packaging options for the revised ASC payment system. First, we considered making no change to the current policy regarding items and services for which payment is packaged into the ASC facility fee. That is, we would continue under the revised ASC payment system to package into the facility fee payment for overhead, payment for all drugs, biologicals, surgical dressings, supplies, splints, casts, and appliances and equipment directly related to the provision of surgical procedures; diagnostic or therapeutic services or items directly related to the provision of a surgical procedure; materials for anesthesia; and IOLs. In addition, we would continue to pay separately under other fee schedules for items and services such as NTIOLs, prosthetic implants and implantable DME surgically inserted at an ASC (DMEPOS fee schedule); laboratory services (clinical lab fee schedule); physician services (MPFS); and X-ray or diagnostic procedures other than those directly related to performance of the surgical procedure (MPFS). Section 416.164(a) addresses the services for which payment is included in the ASC facility fee, and § 416.164(b) addresses those services that are not included in the ASC facility fee.

We also considered proposing to apply the OPPS packaging rules to the ASC payment system and to pay under the new ASC system the same way we pay under the OPPS for items and services directly related to a surgical procedure. If we adopted this option, payment for certain imaging procedures, drugs, biologicals, and contrast agents directly related to performing a surgical procedure would not be packaged into the facility fee for the procedure but would, instead, be paid separately. Conversely, payment for most surgically implanted devices and implantable DME *would* be packaged.

Each of the preceding two options have characteristics that are inconsistent with a fundamental principle of a prospective payment system, which is to base payment on large bundles of items and services so as to promote the efficient provision of services. To preserve as much as possible the elements of a prospective payment system within the revised ASC payment system, we are proposing a third option. That is, we are proposing to continue the current policy of packaging into the ASC facility fee payment all direct and indirect costs incurred by the facility to perform a surgical procedure. This would include payment for all drugs, biologicals, contrast agents, anesthesia materials, and imaging services, as well as the other items and services that are currently packaged into the ASC facility fee as listed in § 416.164(a).

In addition, we are proposing to cease making separate payment for implantable prosthetic devices and implantable DME inserted surgically at an ASC. Instead, under the revised payment system, we are proposing to package into the ASC facility fee payment for implantable prosthetic devices and implantable DME when they are surgically inserted, as we do under the OPPS.

However, we are proposing to continue excluding from payment as part of the ASC facility fee the other services addressed in § 416.164(b). That is, payment for items and services for which payment is made under other Part B fee schedules, with the exception of implantable prosthetic devices and implantable DME, would not be included in the ASC facility fee. Payment for items and services, such as physicians' professional services, for laboratory, X-ray or diagnostic procedures (other than those directly related to performance of the surgical procedure), nonimplantable prosthetic devices, ambulance services, leg, arm, back and neck braces, artificial limbs, and durable medical equipment for use in the patients' home would not be included in the ASC facility fee.

We are proposing this option for a number of reasons. First, this approach to packaging is most consistent with the principles of a prospective payment system. Second, we believe that ASCs generally treat a less complex and severely ill patient case mix and, as a result, we believe that ASCs are less likely to provide on a regular basis many of the separately paid items and services that patients might receive more consistently in a hospital outpatient setting. Thus, we do not believe there is a need to pay for these services separately in ASCs, because that would unbundle some items and services that are currently packaged into the ASC facility fee, reduce incentives for cost-efficient delivery of services at ASCs, and increase the complexity of the revised ASC payment system. In addition, we believe it is critical to continue to focus the ASC payment system on appropriate payment for surgical services provided in ASCs.

Moreover, after careful analysis of OPPS claims for surgical procedures, we were unable to identify ancillary items and services that are repeatedly and consistently reported separately in association with specific ambulatory surgical procedures. Rather, the OPPS claims for surgical procedures were of two types: one group showed a broad range of items and services that were provided on the same day that a surgical procedure was performed in the hospital outpatient department, only some of which were likely to be directly related to the surgical procedure; the second group of claims revealed that many surgical procedures are only infrequently associated with ancillary items and services paid separately under the OPPS. Therefore, we are proposing to reflect this proposed packaging policy in proposed new § 416.164.

We are seeking comments from ASC clinical and administrative staff and from physicians who perform surgery at ASCs regarding nonsurgical ancillary services or items that are directly related to a surgical procedure that would be paid separately under the OPPS but that would be packaged under our proposal for the revised ASC payment system. We are specifically requesting that commenters provide data to indicate the frequency with which specific items and services are typically furnished in association with given procedures, the reasons why one patient might require the additional items and services whereas another patient would not, and the costs of those items and services relative to the other costs incurred to perform the associated surgery.

4. Payment for Corneal Tissue Under the Revised ASC Payment System

(If you choose to comment on issues in this section, please include the caption ''ASC Payment for Corneal Tissue'' at the beginning of your comment.)

In a memorandum dated May 21, 1992, CMS (known at the time as the Health Care Financing Administration or ''HCFA'') notified Regional Administrators that carriers could pay corneal tissue acquisition costs when HCPCS code V2785 (Processing, preserving and transporting corneal tissue), is reported with corneal transplant procedures performed in an ASC. The memorandum indicated that payment for corneal tissue acquisition costs is subject to the usual copayment

and deductible requirements, and could be paid as an add-on to either the ASC facility fee or the physician's fee for corneal transplant surgery performed at an ASC. In the June 12, 1998 proposed rule to revise the ASC ratesetting methodology and payment rates, we proposed to package the costs incurred by an ASC to procure corneal tissue into the payment for the associated cornea transplant procedure rather than continue making separate payment for those costs (63 FR 32312 and 32313). We also proposed to package corneal tissue acquisition costs into the APC payment for corneal transplant procedures in the September 8, 1998 proposed rule to implement the OPPS (63 FR 47760).

We received numerous comments from physicians, eye banks, and health care associations opposing both proposals. In the April 7, 2000 final rule with comment period, which implemented the OPPS, we summarize the comments that we received in response to the September 8, 1998 proposal, and we determined that we would not implement our proposal to package payment under the OPPS for corneal tissue costs but would, instead, make separate payment based on hospitals' reasonable costs to procure corneal tissue (65 FR 18448 and 18449). Because we never made final the changes in the ASC payment rates and ratesetting methodology that we proposed in the June 12, 1998 **Federal Register**, the policy issued in the June 1992 memorandum remains in effect, which allows carriers to make separate payment for the costs incurred to procure corneal tissue for transplant at an ASC.

We are proposing under the revised ASC payment system to continue to pay ASCs separately, based on their invoiced costs, for the procurement of corneal tissue. We have no evidence to suggest that costs incurred to procure corneal tissue are any less variable now than they were in 1992, in 1998 or in 2000. If we were to package payment for the procurement of corneal tissue into the APC for corneal transplant procedures, we believe the resulting payment rate would continue to overpay those facilities that are able to acquire corneal tissue at little or no cost through philanthropic organizations and underpay those facilities that must pay for corneal tissue processing, testing, preservation, and transportation costs. Therefore, we are proposing to include in proposed new § 416.164, our proposal to exclude payment for corneal tissue furnished in an ASC on or after January 1, 2008, from the ASC facility payment rate.

We invite comment and data that support or challenge this proposal to continue paying ASCs for corneal tissue on an acquisition cost basis.

5. Proposed Payment for Office-Based Procedures

(If you choose to comment on issues in this section, please include the caption ''ASC Payment for Office-Based Procedures'' at the beginning of your comment.)

Since the inception of the ASC benefit, procedures that are commonly performed or that can be safely performed in a physician's office have generally been excluded from the ASC list. For the sake of convenience, we refer to these procedures as ''office-based'' in this preamble discussion. Over the past 15 years, physicians and ASC associations have urged CMS to add office-based procedures to the ASC list or to retain on the ASC list procedures that were originally performed most commonly in an institutional setting, but that have subsequently moved to an office setting as surgical techniques and technology have advanced. Representatives of the ASC industry argue that although, for most patients, the office is an appropriate setting for most high volume office procedures, there are some patients for whom an ASC or another more resource-intensive setting is required. The physician may decide that a facility setting is necessary for individual patients for various clinical reasons, such as the need for more nursing staff, a sterile operating room, or a piece of equipment not typically available in the office setting. CPT code 52000 (Cystourethroscopy (separate procedure)) is a prime example of a high volume procedure that is performed more than 80 percent of the time in an office setting, but for which a small number of patients require resources usually available only at an ASC or hospital. Unless we make an exception to the criteria that currently govern which procedures comprise the ASC list and allow an office-based procedure to remain on the ASC list, as we have done with CPT code 52000, the hospital would be the only facility setting available as an alternative to the office setting. ASC industry commenters assert that this limitation is burdensome both to physicians and to beneficiaries and could, in some cases, limit beneficiary access to needed surgery.

We generally interpret ''office-based'' or ''commonly performed in a physician's office'' to mean a surgical procedure that the most recent BESS data available indicate is performed more than 50 percent of the time in the physician's office setting. In section XVIII.B.1 of this preamble, we are proposing to expand the ASC list to allow payment for *all* surgical procedures, except those procedures that pose a significant safety risk or require an overnight stay. Because office-based surgical procedures typically do not pose a significant safety risk and do not require an overnight stay, we are proposing not to exclude them from payment of an ASC facility fee under the revised ASC payment system. However, we are seeking comment on the appropriateness of excluding office-based procedures or procedures that require relatively inexpensive resources to perform from the approved ASC list of procedures. We recognize that paying an ASC facility fee for office-based procedures based on OPPS relative payment weights could have a significant impact on Medicare program costs. Approximately two-thirds of the additional procedures for which we propose to not exclude for payment beginning in CY 2008 are office-based, that is, they are performed in the physician office more than 50 percent of the time. The Medicare payment for many of these procedures under the MPFS would be lower than the payment for the same procedures when they are performed in an ASC where the facility fee is based on OPPS relative weights. The separate physician payment and facility payment when the procedures are performed in an ASC would exceed the combined payment when they are performed in the physician office. Therefore, ASC payment rates based on the OPPS relative payment weights could result in a significant program cost were these high volume procedures to shift from the office to the ASC setting.

One reason why we are concerned if there were to be a sizable shift of office-based procedures to ASCs is the impact that would have on ASC payments in light of the statutory requirements that the revised ASC payment system be designed to result in the same aggregate amount of expenditures as would be made if the revised payment system were not implemented. (See section XVIII.A.1. of this preamble for a discussion of this requirement). An influx of high-volume, relatively low cost office-based procedures into the ASC setting under the revised payment system could lower the payment amounts for other procedures paid for in the ASC due to the constraints of budget neutrality. In other words, we would have to scale the ASC conversion factor downward in order for estimated

aggregate expenditures under the revised system to not exceed what they would have been if the new payment system were not implemented. Payment for procedures with relatively high payments would have to be reduced in order to offset increased aggregate costs resulting from an influx of relatively low cost, high volume office procedures shifting to ASCs. (See section XVIII.C.10. of this preamble for a detailed discussion of our proposal for calculating an ASC conversion factor.)

We are committed to refining Medicare payment systems wherever possible to prevent payment incentives from inappropriately driving decisions about where to perform a surgical procedure when those decisions should be based on clinical considerations. We strive to promote value-based purchasing in all Medicare payment systems that leads to significant positive effects on the health of Medicare beneficiaries by improving quality and efficiency in the delivery of health services. We are also committed to ensuring Medicare payments that are efficient and reasonable. To mitigate the impact of office-based procedures migrating to the more expensive ASC setting if we were to implement our proposal not to exclude them from payment of an ASC facility fee under the revised ASC payment system, we are proposing to cap payment for office-based surgical procedures for which payment of an ASC facility fee would be allowed under the revised payment system as of January 1, 2008, at the lesser of the MPFS nonfacility practice expense payment or the ASC rate under the revised ASC payment system. We also are proposing to exempt procedures that are on the ASC list as of January 1, 2007, that meet our criterion for designation as office-based, from the payment limitation proposed for office-based procedures for which payment of an ASC facility fee would be allowed for the first time beginning January 1, 2008. Accordingly, we are proposing to incorporate in proposed new § 416.171(e) the limitation on payment for these procedures beginning January 1, 2008.

As discussed elsewhere in this proposed rule, we are proposing to limit payment for office-based procedures in an attempt to mitigate potentially inappropriate migration of services from the physician office setting to the ASC. Alternatively, we could entirely exclude office-based procedures or procedures that require relatively inexpensive resources to perform from the approved ASC list of procedures, although this is not the approach we are advancing. In considering value-based purchasing, we seek comment concerning whether procedures that are currently primarily office-based or that require relatively inexpensive resources are most efficiently and effectively provided in the ASC facility setting, which typically possesses greater surgical capacity than such procedures would generally require.

When we started to identify the codes that we would propose to classify as office-based beginning in CY 2008, we encountered some anomalous cases that required further refinement of our office-based criterion beyond strict application of a 50-percent utilization threshold. For example, we identified some CPT codes that meet the 50-percent office utilization threshold for which a nonfacility practice expense amount has not been developed under the MPFS. We are proposing to classify as office-based any surgical codes that our physician claims data indicate are performed more than 50 percent in an office setting, even if the codes lack a nonfacility practice expense RVU under the MPFS. We further propose to cap payment for these procedures, as appropriate, once a nonfacility practice expense RVU is established. Until that time, we are proposing to calculate payment for these office-based surgical CPT codes using the methodology we propose in sections XVIII.C.11.c. and d. below, for other surgical procedures. Similarly, until a national nonfacility practice expense RVU is established for office-based surgical CPT codes that are ''carrier priced'' under the MPFS, we are proposing to calculate the ASC facility payment using the same methodology that we are proposing for surgical procedures that are not office-based. Application of the cap to codes designated as office-based would be updated through rulemaking as part of the annual ASC payment update.

In applying the data-based 50-percent threshold, we discovered some contradictions in the data that required us to further refine our definition of office-based. For example, we noted instances in which seemingly very similar procedures had inconsistent site of service utilization. The BESS data showed high levels of office utilization for some complex procedures which we expected to be performed infrequently in an office setting whereas simpler but related procedures showed lower levels of office utilization.

We therefore undertook another, more detailed level of review and identified groups of CPT surgical codes related to procedures that are performed 50 percent or more of the time in the office setting to determine if there was a logical correlation between procedure complexity within a group of related procedures and the frequency with which those procedures were performed in the office setting. For example, according to CPT coding, the following three codes are related:

13120, Repair, complex, scalp arms and/or legs; 1.1cm to 2.5 cm

13121, Repair, complex, scalp arms and/or legs; 2.6 cm to 7.5 cm

13122, Repair, complex, scalp arms and/or legs; each additional 5 cm or less

As is often the case for groups of related codes in the CPT coding system, the first of these codes is the least complex clinically and, in this example, the complexity of the procedure increases in proportion to the increase in the size of the area to be repaired. If utilization data indicated that CPT code 13122 was performed in the office 67 percent of the time in CY 2005, we would expect to find that both CPT codes 13120 and 13121 were also performed in the physician office more than 50 percent of the time during that year. Because the most complex procedure was provided in the office most of the time, logically, the less complex procedures would also have been performed in that site of service. However, the BESS data showed that this was not always the case.

So, although our expectation was that, the less complex procedures within a group of related procedure codes would typically be performed most often in the office and the more complex procedures less often in the office, there are instances in which the less complex procedures with the code group were billed more often in an ASC or hospital outpatient department and the more complex procedures within the code billed in the office setting.

In our analysis of the BESS site of service data, we also took into consideration the volume of cases represented in the data. There were a few instances in which we initially identified a procedure as office-based because the data indicated that 100 percent of the cases were performed in the physician office. However, closer inspection revealed that there was only one case reported for the procedure with physician's office as the site of service. We were concerned about using such low volume as the basis for identifying a procedure as office-based. Because of the unevenness of the data associated with some of the codes we initially classified as office-based, we conducted a code-by-code analysis to buttress inconclusive data with the clinical judgment of our medical advisors. As a result, on the basis of clinical judgement overriding inadequate or insufficient

claims data, there are some procedures that we deem meet the 50-percent threshold when taken in isolation from other closely related codes that we have designated as office-based.

We are proposing to assess each year based on the most recent available BESS and other data available to us whether there are additional procedures that we would propose to classify as office-based. We would solicit comment on proposed classification of additional codes as office-based as part of the annual OPPS/ASC rulemaking cycle. In addition, we are proposing that once we identify a procedure as office-based, that classification would not change in future updates of the ASC payment system. We reason that once a procedure becomes safe enough to be performed in more than 50 percent of cases in the office setting, it would be improbable for it to revert to an institutional setting.

To summarize, the list of codes that we propose as office-based in this rule takes into account the most recent available volume and utilization data for each individual procedure code and, if appropriate, the utilization and volume of related codes. While we are proposing to apply the office-based designation only to procedures that would no longer be excluded from payment of an ASC facility fee beginning in CY 2008, were we to exclude office-based services from ASC payments, we expect that the same approach to developing and updating the set of procedures in the CPT surgical code range that we consider to be office-based would be applicable. Finally, we are concerned that our proposal to allow payment of an ASC facility fee for office-based procedures, even if the ASC payment amount were capped at the lesser of the MPFS nonfacility practice expense payment or the revised ASC rate, would result in a downward adjustment to ASC payments overall, and would increase Medicare spending.

We propose to exempt all procedures on the CY 2007 ASC list from application of the office-based classification. The procedures that we are proposing to designate as subject to the office-based payment limit are identified in new Addendum CC of this proposed rule. Those procedures for which the proposed CY 2008 payment would be based on the MPFS nonfacility practice expense RVU are flagged in Addendum BB. The ASC relative payment weight shown for procedures in Addendum BB that would be capped by the MPFS nonfacility practice expense RVU has been adjusted to reflect the capped payment amount. We remind readers that the ASC payment rates in Addendum BB of this proposed rule are based on proposed CY 2007 OPPS relative payment weights and proposed MPFS nonfacility practice expense RVUs. The final ASC relative weights and payment amounts for CY 2008 would be different from the rates published in this proposed rule because they would take into account the CY 2008 updates of both the OPPS and the MPFS. The proposed and final ASC relative weights and payment amounts for CY 2008 would be published in the **Federal Register** during the proposed and final rulemaking cycles for the CY 2008 OPPS.

6. Payment Policy for Multiple Procedure Discounting

We are proposing to mirror the OPPS policy for discounting when a beneficiary has more than one surgical procedure performed on the same day at an ASC. The current policy for multiple procedure discounting in the ASC, as specified in § 416.120(c)(2)(ii), is based on a simple count of procedures performed on the same day. The most costly procedure is paid the full amount and all other procedures are discounted by half.

Under the OPPS, certain surgical procedures are not subject to the discounting policy. Generally, the procedures that are exempted are those performed to implant costly devices. They are not discounted even when performed in association with other surgical procedures because the cost of the implantable device does not change, so resource savings due to efficiencies would be minimal.

Until now, there has been no reason to exempt any procedure from the multiple procedure discounting policy in ASCs because separate payments have been made for implantable devices. Thus, although the facility payment for the procedure may have been discounted, the cost of the device was paid outside of that rate and was unaffected by the multiple procedure discount.

Under the revised ASC payment system, we are proposing to package into the payment for the procedure payment for implantable devices in the ASC, as in the OPPS. Because we are trying wherever possible to implement parallel payment policy across both systems, we are proposing to adopt the OPPS discounting policy that is applied more specifically to surgical procedures so that the costs of performing multiple procedures that require implantation of costly devices are taken into account. Thus, payment for the same set of multiple procedures in the OPPS and the ASC would be made using similar packaging and payment rules.

Table 46 below lists the procedures that would be exempt from multiple procedure discounting. These exempt procedures are those surgical procedures proposed for payment of an ASC facility fee that are assigned a status indicator other than ''T'' under the OPPS, to indicate that a multiple surgical procedure reduction does not apply. We are proposing to update this list annually in the OPPS/ASC proposed rule, soliciting comment on the list.

We are proposing to incorporate our proposed policy on multiple procedure discounts in proposed new § 416.172(e).

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Table 46.--Procedures Proposed for Exemption from Multiple Procedure Discounting

HCPCS Code	Short Descriptor	APC
61885	Insrt/redo neurostim 1 array	0039
63650	Implant neuroelectrodes	0040
64555	Implant neuroelectrodes	0040
64560	Implant neuroelectrodes	0040
64561	Implant neuroelectrodes	0040
64565	Implant neuroelectrodes	0040
29020	Application of body cast	0058
29025	Application of body cast	0058
29040	Application of body cast	0058
29049	Application of figure eight	0058
29058	Application of shoulder cast	0058
29085	Apply hand/wrist cast	0058
29086	Apply finger cast	0058
29105	Apply long arm splint	0058
29125	Apply forearm splint	0058
29126	Apply forearm splint	0058
29130	Application of finger splint	0058
29131	Application of finger splint	0058
29200	Strapping of chest	0058
29220	Strapping of low back	0058
29240	Strapping of shoulder	0058
29260	Strapping of elbow or wrist	0058
29280	Strapping of hand or finger	0058
29440	Addition of walker to cast	0058
29450	Application of leg cast	0058
29505	Application, long leg splint	0058
29515	Application lower leg splint	0058
29520	Strapping of hip	0058
29530	Strapping of knee	0058
29540	Strapping of ankle and/or ft	0058
29550	Strapping of toes	0058

HCPCS Code	Short Descriptor	APC
29580	Application of paste boot	0058
29590	Application of foot splint	0058
29700	Removal/revision of cast	0058
29705	Removal/revision of cast	0058
29715	Removal/revision of cast	0058
29720	Repair of body cast	0058
29730	Windowing of cast	0058
29740	Wedging of cast	0058
29750	Wedging of clubfoot cast	0058
29799	Casting/strapping procedure	0058
63655	Implant neuroelectrodes	0061
64575	Implant neuroelectrodes	0061
64577	Implant neuroelectrodes	0061
64580	Implant neuroelectrodes	0061
64581	Implant neuroelectrodes	0061
36430	Blood transfusion service	0110
36440	Bl push transfuse, 2 yr or <	0110
36450	Bl exchange/transfuse, nb	0110
38999	Blood/lymph system procedure	0110
36511	Apheresis wbc	0111
36512	Apheresis rbc	0111
36513	Apheresis platelets	0111
36514	Apheresis plasma	0111
38205	Harvest allogenic stem cells	0111
38206	Harvest auto stem cells	0111
38242	Lymphocyte infuse transplant	0111
36515	Apheresis, adsorp/reinfuse	0112
36516	Apheresis, selective	0112
36522	Photopheresis	0112
38230	Bone marrow collection	0123
38241	Bone marrow/stem transplant	0123
G0104	CA screen;flexi sigmoidscope	0159
64553	Implant neuroelectrodes	0225
64573	Implant neuroelectrodes	0225
68200	Treat eyelid by injection	0230
65450	Treatment of corneal lesion	0231
67500	Inject/treat eye socket	0231
68760	Close tear duct opening	0231
68761	Close tear duct opening	0231
68810	Probe nasolacrimal duct	0231
53440	Male sling procedure	0385
53444	Insert tandem cuff	0385

HCPCS Code	Short Descriptor	APC
54400	Insert semi-rigid prosthesis	0385
53445	Insert uro/ves nck sphincter	0386
53447	Remove/replace ur sphincter	0386
54401	Insert self-contd prosthesis	0386
54405	Insert multi-comp penis pros	0386
54410	Remove/replace penis prosth	0386
54416	Remv/repl penis contain pros	0386
37250	Iv us first vessel add-on	0416
37251	Iv us each add vessel add-on	0416
29010	Application of body cast	0426
29015	Application of body cast	0426
29035	Application of body cast	0426
29044	Application of body cast	0426
29055	Application of shoulder cast	0426
29065	Application of long arm cast	0426
29075	Application of forearm cast	0426
29305	Application of hip cast	0426
29325	Application of hip casts	0426
29345	Application of long leg cast	0426
29355	Application of long leg cast	0426
29358	Apply long leg cast brace	0426
29365	Application of long leg cast	0426
29405	Apply short leg cast	0426
29425	Apply short leg cast	0426
29435	Apply short leg cast	0426
29445	Apply rigid leg cast	0426
29710	Removal/revision of cast	0426
19295	Place breast clip, percut	0657
31620	Endobronchial us add-on	0670
33282	Implant pat-active ht record	0680
62252	Csf shunt reprogram	0691
62367	Analyze spine infusion pump	0691
62368	Analyze spine infusion pump	0691
65205	Remove foreign body from eye	0698
65210	Remove foreign body from eye	0698
65220	Remove foreign body from eye	0698
65222	Remove foreign body from eye	0698
65430	Corneal smear	0698
67820	Revise eyelashes	0698
67938	Remove eyelid foreign body	0698
68040	Treatment of eyelid lesions	0698
68801	Dilate tear duct opening	0698
68840	Explore/irrigate tear ducts	0698
19298	Place breast rad tube/caths	1524

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7. Proposed Geographic Adjustment

(If you choose to comment on issues in this section, please include the caption ''ASC Wage Index'' at the beginning of your comment.)

Currently, Medicare adjusts 34.45 percent of the national ASC payment rates using wage index values and localities that were established under the IPPS prior to implementation of the new Core Based Statistical Areas (CBSAs) issued by OMB in June 2003. Medicare currently adjusts 60 percent of national OPPS payment rates by the IPPS wage index value assigned to hospitals using the June 2003 OMB definitions for geographical statistical areas and wage adjustments required under Pub. L. 108–173.

Since 1990, ASC payments have been adjusted for regional wage variations using the hospital IPPS wage index values. We believe that standardization continues to be appropriate in recognition of widely varying labor market costs tied to geographic localities. We also believe that it is advisable to maintain the consistency in locality designations between ASCs and hospitals and acknowledge parity of labor costs between ASCs and HOPDs that are competing for staff in the same locality. Therefore, we are proposing to apply to ASCs the IPPS pre-reclassification wage index values associated with the June 2003 OMB geographic localities, as recognized under the IPPS and OPPS, to adjust national ASC payment rates for geographic wage differences under the revised payment system.

Although we have not collected new data to identify whether the current labor-related share is correct, the results of a 1994 survey of ASC costs supported the current 34.45 percent labor adjustment factor, and we have received no complaints from the ASC community about our continued use of the 34.45/65.55 ratio of labor to nonlabor costs for purposes of adjusting payments for regional wage differences. Moreover, we believe it is reasonable to expect ASCs to have a lower labor adjustment factor than that of a hospital. For example, most OPPS hospital outpatient departments are staffed 24 hours per day to provide emergency department services and observation care. Therefore, we are proposing to continue using 34.45 percent as the labor adjustment factor for regional wage differences under the ASC revised payment system, beginning in CY 2008. We are proposing to establish rules governing this proposed new § 416.172(c).

8. Proposed Adjustment for Inflation

(If you choose to comment on issues in this section, please include the caption ''ASC Inflation'' at the beginning of your comment.)

As noted above, section 1833(i)(2)(C)(iv) of the Act, as amended by section 626(a) of Pub. L. 108–173, requires the adjustment of ASC facility services amounts for inflation for FY 2005, the last quarter of CY 2005, and each of CYs 2006 through 2009, to equal zero percent. Otherwise, section 1833(i)(2)(C)(i) of the Act provides that ASC facility services amounts are to be adjusted by the percentage increase in the CPI–U during years when the ASC amounts are not updated.

As explained in section II.C. of the preamble of this proposed rule, the OPPS conversion factor is updated annually using the hospital inpatient market basket percentage increase. Although section 626(d) of Pub. L. 108–173 suggests that the Congress found merit in linking the ASC payment system to the OPPS relative payment weights and APC groups, it did not require that the new ASC payment system be updated using the hospital market basket that is the basis for annual OPPS updates. However, we believe that an update of the ASC amount is performed through the annual relative ASC payment weight adjustments that we propose in section XVIII.C.11.d.(1) below, which obviates the requirement for the statutory CPI adjustment. Nonetheless, although we are not compelled to do so by the statute, we are proposing under the revised ASC payment system, beginning in CY 2008, to apply a CPI–U adjustment to update the ASC conversion factor for inflation on an annual basis, in accordance with the statutory formula. The CPI–U adjustment in CY 2008 and CY 2009 would equal zero. Beginning in CY 2010, we would update the ASC conversion factor by the percentage increase in the CPI–U (U.S. city average) as estimated for the 12-month period ending with the midpoint of the year involved. As we explain in section XVIII.C.11.d.(2) below, we are proposing to adjust the conversion factor for inflation annually to ensure that ASC payments keep up with cost increases attributable to inflation. Accordingly, we are proposing to establish rules in proposed new §§ 416.171 and 416.172 to reflect our proposed policies for standardizing labor-related costs, applying an inflationary adjustment, and calculating a conversion factor, respectively under the proposed new payment system beginning January 1, 2008.

9. Proposed Beneficiary Coinsurance

(If you choose to comment on issues in this section, please include the caption ''ASC Coinsurance'' at the beginning of your comment.)

Payment for ASC facility services is subject to the Medicare Part B deductible and coinsurance requirements. Currently, Medicare pays participating ASCs 80 percent of a prospectively determined rate, adjusted for regional wage variations. The beneficiary deductible and coinsurance make up the other 20 percent.

Section 626(c) of Pub. L. 108–173 amended section 1833(a)(1) of the Act to provide that, beginning with the implementation date of the revised payment system, the Medicare program payment to ASCs shall equal 80 percent of the lesser of the actual charge for the services or the payment amount that we determine under the revised payment system for the services. We are proposing to make this change and to continue to maintain the beneficiary deductible and coinsurance at 20 percent. We are proposing to reflect this statutory requirement in proposed new § 416.172(b) and (d).

10. Proposal To Phase In Implementation of Payment Rates Calculated Under the CY 2008 Revised ASC Payment System

(If you choose to comment on issues in this section, please include the caption ''ASC Phase In'' at the beginning of your comment.)

We discuss in section XXVII.D. of this preamble our analysis of the impact the revised ASC payment system and estimated payment rates proposed for implementation in CY 2008 could have on certain ASCs that specialize in or perform high volumes of procedures for which payment under the new system would decrease. We want to ensure that the revised payment system does not cause a sudden, unwarranted migration of services from ASCs to other ambulatory settings, or the reverse; that ASCs would have an opportunity to balance their Medicare case mix between procedures whose rates decrease and procedures whose rates increase; and, that beneficiaries and their physicians would continue to have a robust choice of sites where important preventive and other surgical services are paid for by Medicare. Therefore, we propose to implement the revised ASC payment system in CY 2008 using transitional payment rates that would be based upon a 50/50 blend of the payment rate for procedures on the CY

2007 list of approved ASC procedures and the payment rate for that procedure calculated under the revised payment methodology described in the next section and reflected in proposed new § 416.171(c). (Procedures added for payment of an ASC facility fee beginning in CY 2008 would be paid the full amount calculated under the revised payment methodology for CY 2008 rather than a blended amount.) We further propose that, in CY 2009, we would fully implement the ASC payment rates calculated under the payment methodology proposed in the next section, discontinuing the blended transitional payment rate for services furnished beginning January 1, 2009. This is proposed in new § 416.171(d).

11. Proposed Calculation of ASC Conversion Factor and Payment Rates for CY 2008

(If you choose to comment on issues in this section, please include the caption ''ASC Conversion Factor'' at the beginning of your comment.)

a. Overview

In section XVIII.C.2 of this preamble, we are proposing to base ASC relative payment weights and rates under the revised system on APC groups and relative payment weights established under the OPPS. In section XVIII.C.4 of this preamble, we are proposing to set the ASC relative payment weight for certain office-based surgical procedures so that the national ASC payment rate does not exceed the MPFS nonfacility practice expense payment. The proposed ASC payment weights are multiplied by an ASC conversion factor to calculate the proposed ASC payment rates. For CY 2008, our current estimate of the budget neutral ASC conversion factor is $39.688. The final ASC conversion factor may be higher or lower than this figure for a number of reasons, including (1) The final OPPS relative payment weights for CY 2008, (2) the final physician fee schedule practice expense payments for CY 2008 and (3) updated utilization data.

b. Budget Neutrality Requirement

Section 626(b) of the MMA amended section 1833(i)(2) of the Act by adding subparagraph (D) to require that in the year the new system is implemented:

''* * * [S]uch system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary * * *''.

The ASC conversion factor is calculated so that aggregate expenditures under the new system are estimated to be the same as the aggregate expenditures for ASC facility services in CY 2008 that would have been paid had the ASC payment system not been revised, taking into consideration the cap on payments in CY 2007 as required under section 5103 of Pub. L. 109–171, which we discuss in section XVII.D., that is, the conversion factor is calculated so the new system is budget neutral.

Note that we consider expenditures in the context of section 626(b) of the Pub. L. 108–173 budget neutrality requirement to mean expenditures from the Medicare Part B Trust Fund. We do not consider expenditures to include beneficiary coinsurance and copayments. We note, however, that the exclusion of beneficiary coinsurance payments does not impact the calculation of the ASC conversion factor under our proposed methodology. (See section XXVI.D. of this preamble for impacts of the revised ASC system on beneficiary coinsurance.)

c. Proposed Calculation of the ASC Payment Rates for CY 2008

We are proposing to calculate the ASC payment rates for CY 2008 as follows:

Estimated payments under the current ASC system

Step 1: To estimate the aggregate amount of expenditures that would be made in CY 2008 under the current ASC payment system, we first multiplied the estimated CY 2008 ASC volume for each CPT code on the current ASC list by the estimated CY 2008 ASC payment rate for the CPT code under the current ASC system. The estimated CY 2008 ASC payment rates are based on the proposed CY 2007 ASC payment rates, which are found in Addendum BB to take into account the OPPS cap on ASC services as required by section 5103 of Pub. L. 109–171 and to reflect the zero percent CY 2008 update for ASC services mandated by section 1833(i)(2)(C) of the Act. We then summed the results over all services on the current ASC list.

Estimated payments under the new ASC system

Step 2: To estimate the aggregate amount of expenditures that would be made in CY 2008, we used estimated CY 2008 OPPS payment amounts instead of estimated CY 2008 ASC payment amounts under the current system, and we multiplied the estimated CY 2008 ASC volume for each CPT code on the current ASC list by the estimated CY 2008 OPPS payment rate for the CPT code. We summed the results over all services on the current ASC list.

Calculate the CY 2008 budget neutrality adjustment

Step 3: To calculate the CY 2008 ASC budget neutrality adjustment, we divided the total expenditures calculated in Step 1 by the total expenditures calculated in Step 2. The result is 0.62.

Apply the CY 2008 budget neutrality adjustment to determine the CY 2008 ASC conversion factor

Step 4: To determine the CY 2008 ASC conversion factor, we multiplied the estimated CY 2008 OPPS CF by the results in Step 3. Our current estimate of the CY 2008 OPPS CF is $64.013. Multiplying the estimated CY 2008 OPPS conversion factor by the 0.62 budget neutrality adjustment yields our current estimate of the CY 2008 ASC conversion factor: $39.688.

Calculate the CY 2008 ASC payment rate under the new ASC system

Step 5: To determine the national ASC payment rate under the new system (including the beneficiary 20 percent coinsurance), we multiplied the ASC conversion factor from Step 4 by the ASC relative payment rate.

The ASC relative payment weights are primarily based on the APC groups and relative payment weights established under the OPPS as described in section XVIII.C.2 of this preamble. However, as described in section XVIII.C.4 of this preamble, the ASC relative payment weights for certain office-based surgical procedures are set so that the national ASC payment rate does not exceed the MPFS nonfacility practice expense payment.

As discussed elsewhere in this proposed rule, we are proposing to limit payment for office-based procedures in an attempt to mitigate potentially inappropriate migration of services from the physician office setting to the ASC. Alternatively, we could entirely exclude office-based procedures or procedures that require relatively inexpensive resources to perform from the approved ASC list of procedures, although this is not the approach we are advancing.

The ASC relative payment weights are listed in Addendum BB of this proposed rule.

Calculate the CY 2008 ASC payment rate under the transition

Step 6: As described in section XVIII.C.10. of this preamble, we are proposing under the revised payment system a 2-year transition to 100 percent implementation of the new ASC payment rates for procedures on the CY 2007 list of approved ASC procedures. In the first year of this transition, the payment rate would be based on 50

percent of the final CY 2007 ASC standard overhead amount and 50 percent of the final payment rate calculated under the revised payment methodology proposed in this section of the preamble.

d. Proposed Calculation of the ASC Payment Rates for CY 2009 and Future Years

(1) Updating the ASC Relative Payment Weights

We are proposing to update the ASC relative payment weights each year using the national OPPS relative payment weights for that calendar year and, for the office-based procedures, the practice expense payments under the physician fee schedule for that calendar year. We further propose to uniformly scale the ASC relative payment weights each year so that estimated aggregate expenditures using updated ASC relative payment weights are the same as estimated aggregate expenditures using the current year ASC relative payment weights. That is, we propose to make the relative payment weights budget neutral to ensure that changes in the relative payment weights from year to year do not cause the estimated amount of expenditures to ASCs to increase or decrease as a function of those changes. For example, we propose to uniformly scale the ASC relative payment weights for CY 2009 so that estimated expenditures for CY 2009 using the updated CY 2009 ASC relative payment weights are the same as they would be using the CY 2008 ASC relative payment weights. We propose to uniformly scale the ASC relative payment weights for CY 2010 so that estimated expenditures for CY 2010 using the updated CY 2010 ASC relative payment weights are the same as they would be using the CY 2009 ASC relative payment weights.

We are proposing to scale the relative payment weights annually because we believe that the purpose of using relative payment weights as part of the rate setting methodology under the revised ASC system is to establish appropriate relativity among surgical procedures paid for in an ASC. Scaling the relative payment weights each year would also serve as a buffer to protect ASCs from sudden changes that could occur under the OPPS. For example, by making the relative payment weights budget neutral under the revised ASC payment system, the ASC relative weights would not drop were there to be a sudden upsurge in costs associated with hospital outpatient emergency or clinic visits relative to outpatient surgical costs. Moreover, making the ASC relative weights budget neutral would shield the ASC payment system against the inadvertent impact of unrelated aggregate changes in OPPS expenditures. We propose to continue this methodology to update the ASC payment system in future years.

(2) Updating the ASC Conversion Factor

In section XVIII.11.d.1, above, we propose to scale the relativity among surgical procedures each year so that aggregate expenditures under the ASC are budget neutral notwithstanding changes in the relative payment weights. In section XVIII.11.c, above, we propose to calculate the ASC payment rates each year as the product of the ASC relative payment weight and the ASC conversion factor which have been adjusted for budget neutrality. Section 1833(i)(2)(C) of the Act requires that if the Secretary has not updated the ASC facility services amounts in a calendar year after CY 2009, the payment amounts shall be increased by the percentage increase in the CPI-U as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

Although we are only required to increase ASC payment rates by the percentage increase in the CPI–U in years when we do not update the ASC payment amounts, beginning with the CY 2008 revised ASC payment system, we propose to update the ASC conversion factor annually using the CPI–U. For example, for CY 2009, the statute requires a zero percent CPI–U increase for ASC services. Therefore, the CY 2009 conversion factor would be equal to the CY 2008 conversion factor. For CY 2010, we would increase the CY 2009 conversion factor by the estimated percent increase in the CPI–U for the 12-month period ending June 30, 2010; in CY 2011, we would increase the CY 2010 conversion factor by the estimated percent increase in the CPI–U for the 12-month period ending June 30, 2011, and so forth, each year thereafter. We propose to apply this adjustment annually to ensure that ASC payments keep up with cost increases attributable to inflation. Moreover, we propose to use the CPI–U to adjust the conversion factor for inflation because we have used the CPI–U to adjust payments to ASCs for inflation since July 1987, when we first updated the ASC payment rates in effect at the time by the projected increase in the CPI–U (52 FR 20467). This proposal is reflected in § 416.167 and § 416.171.

e. Alternative Option for Calculating the Budget Neutrality Adjustment Considered

We considered an alternative approach to calculating the budget neutrality adjustment under the new payment system, which would take into account the effects of the migration of procedures between ASCs, physicians' offices, and hospital outpatient departments that might be attributable to the new ASC payment system. In the following discussion the phrase ''new ASC procedure'' refers to a procedure not currently on the ASC list of approved procedures that we are proposing for inclusion on the ASC list of approved procedures beginning in CY 2008.

Under this alternative, we assumed that 25 percent of the hospital outpatient department utilization for new ASC procedures would migrate to the ASC and we assumed that 15 percent of the physician office utilization for new ASC procedures would migrate to the ASC. We believe that our assumptions of a 25 percent and 15 percent migration from hospital outpatient departments and physician offices to ASCs, respectively, are reasonable given the general utilization relationships between these settings for services currently on the ASC list. For services on the current ASC list that are predominately performed in ASC and outpatient hospital department settings, they are on average performed 30 percent of the time in the ASC setting. For services on the current ASC list that are predominately performed in the ASC and physician office settings, they are on average performed 17 percent of the time in the physician office setting. We assumed that new ASC services would migrate at slightly lower rates in the first year of the revised ASC system, yielding our migration assumptions of 25 percent for the hospital outpatient department setting and 15 percent for the physician office setting.

We also assumed that the net impact of migration on services currently on the ASC list is negligible. We note that payment rates for the current highest volume ASC procedures would generally decrease under the proposed new ASC system, and the lower volume ASC procedures would experience significant payment increases. We believe it is reasonable to assume that some of the higher volume services will migrate from ASCs to other settings, and some of the current lower volume procedures will migrate to the ASC setting as a result of the payment changes.

In order to calculate the budget neutrality adjustment, first, we estimated expenditures that would occur if we did not revise the ASC payment system. We estimated CY 2008 expenditures if the ASC payment weights were not revised and the ASC list of approved procedures was not expanded. As described below (see Step 1).

Estimated payments under the current system

Step 1: Hospital outpatient department migration valued using estimated CY 2008 OPPS payment rates

(a) Assuming 25 percent of the outpatient hospital department utilization for new ASC procedures will migrate to the ASC, multiple 0.25 times the hospital outpatient department utilization for each new ASC procedure.

(b) For each new ASC procedure, multiple the results of Step 1(a) by the estimated CY 2008 OPPS payment rate for the procedure.

(c) Sum the results of Step 1(b) across all new ASC procedures.

Step 2: Physician office migration valued using estimated CY 2008 physician payment rates

(a) Assuming 15 percent of the physician office utilization for new ASC procedures will migrate to the ASC, multiple 0.15 times the physician office utilization for each new ASC procedure.

(b) For each new ASC procedure, multiple the results of Step 2(a) by the estimated CY 2008 physician office payment rate for the procedure.

(c) Sum the results of Step 2(b) across all new ASC procedures.

Step 3: Current ASC services valued using the estimated CY 2008 ASC payment rates under the current ASC system

(a) This is described under Step 1 in the Proposed Calculation of the ASC Conversion Factor section above.

Step 4: Sum the results of Steps 1–3.

Estimated payments under the new system

Step 5: Hospital outpatient department migration valued using estimated CY 2008 OPPS payment rates

(a) Same as Step 1 in this section.

Step 6: Identify new ASC procedures currently considered to be office-based (for example, insert examples and see Addendum BB)

Step 7: Physician office migration for new ASC procedures currently considered to be office based valued using the estimated CY 2008 OPPS payment rates capped at the estimated CY 2008 physician office payment rates

(a) For each new ASC procedure considered to be office based, multiply the results of Step 2(a) by the lesser of:

(1) The estimated CY 2008 OPPS rate for the procedure; and

(2) The estimated CY 2008 physician fee schedule office rate for the procedure.

(b) Sum the results of Step 7(a) across all new ASC procedures considered to be office-based.

Step 8: Physician office migration for new ASC procedures not currently considered office based valued using the estimated CY 2008 OPPS rates

(a) For each new ASC procedure not considered to be office based, multiply the results of Step 2(a) by the estimated CY 2008 OPPS rate for the procedure.

(b) Sum the results of Step 8(a) across all new ASC procedures not considered to be office based.

Step 9: Physician office migration valued using the estimated CY 2008 physician fee schedule out-of-office payment rate.

(a) For each new ASC procedure, multiple the results of Step 2(a) by the estimated CY 2008 out of office physician rate for the procedure.

(b) Sum the results of Step 9(a) across all new ASC procedures.

Step 10: Current ASC services valued using the estimated CY 2008 OPPS payment rates

(a) This is described under Step 2 in this section.

Step 11: Sum the results of Steps 5, 7–10.

Calculate the budget neutrality adjustment

Step 12: Divide the result of Step 4 by the result of Step 11.

Step 13: The application of the cap at the estimated CY 2008 physician office payment rates that occurs in Step 7 is dependent on the ASC conversion factor. The ASC budget neutrality adjustment resulting from Step 12 is calibrated to take into account the interactive nature of the ASC conversion factor and the physician office payment cap.

The resulting budget neutrality adjustment is 0.62, indicating that under the migration assumptions described above the difference between our proposed budget neutrality adjustment without migration (0.62) and this alternative budget neutrality adjustment with migration (0.62) is equal rounded to the nearest hundredth.

Discussion of the alternative calculation of the budget neutrality adjustment:

We have chosen to propose calculation of the budget neutrality adjustment based on the CY 2007 final ASC list of approved services and current ASC utilization because we believe this is the most appropriate approach to estimating expenditures so as to result in a budget neutral payment system in CY 2008. We have no data which would enable us to precisely estimate the net potential migration of services between the ASC setting, the outpatient hospital setting, and the physician office setting that might result from implementation of the new ASC payment system. Moreover, basing our estimate of expenditures on current ASC utilization without including migration from other sites of service is consistent with how we estimate expenditures for purposes of maintaining budget neutrality in other Medicare payment systems.

We expect that some commenters may believe it is more appropriate to estimate the ASC budget neutrality adjustment taking into account the potential migration of services between the ASC setting, the outpatient hospital setting, and the physician office setting. We welcome data supporting the use of specific migration assumptions in the calculation of the ASC budget neutrality adjustment. We describe above the budget neutrality calculation under the alternative approach based on our current best estimate of the potential migration of services between the different settings so as to facilitate and stimulate comment and to encourage the submission of pertinent quantitative evidence of surgical migration resulting from changes in payment rates. We welcome data on all of the migration assumptions under this alternative approach. We note again that under the reasonable migration assumptions described above, our proposed budget neutrality calculation without migration (0.62) and the alternative budget neutrality adjustment with migration (0.62) is equal rounded to the nearest hundredth. However, if we exclude office-based procedures from the approved list of procedures, under the alternative budget neutrality adjustment that takes into account migration across different practice settings, payment rates for the ASC services remaining on the list (those procedures that are not office-based) would be slightly higher due to the statutory budget neutrality requirement.

12. Proposed Annual Updates

(If you choose to comment on issues in this section, please include the caption ''ASC Updates'' at the beginning of your comment.)

Currently, we update the ASC list every 2 years through the notice and comment regulation process. We make additions to and deletions from the ASC list based on clinical judgment and data that are available regarding utilization of

care settings. The last update was published in the May 4, 2005 **Federal Register** (70 FR 23690) and the update for CY 2007 is proposed in section XVII of this preamble. The process we follow currently to update the ASC list is explained in section XVII of this preamble.

Under the revised ASC payment system, which would be implemented effective January 1, 2008, we are proposing to update on an annual calendar year basis the ASC conversion factor, the relative payment weights and APC assignments, the ASC payment rates, and the list of procedures for which Medicare would not make payment of an ASC facility fee. To the extent possible under the rules and policies of the revised ASC payment system, we are proposing to maintain consistency between the OPPS and the ASC payment systems in the way we treat new and revised HCPCS and CPT codes for payment under the ASC payment system. We also are proposing to invite comment as part of the annual update cycle to determine if there are procedures that we exclude from payment in the ASC setting that merit reconsideration as a result of changes in clinical practice or innovations in technology.

We are proposing to update the ASC list and payment system as part of the annual proposed and final rulemaking cycle updating the hospital OPPS. We believe that including the ASC update as part of the OPPS rulemaking cycle would ensure that updates of the ASC payment rates and the list of surgical procedures for which Medicare pays an ASC facility fee would be issued in a regular, predictable, and timely manner. Moreover, the ASC payment system would be updated concurrent with changes in the APC groups and the OPPS inpatient list, making it easier to predict changes in payment for particular services from year to year.

In the first part of CY 2007, we are proposing to issue a final rule in which we would respond to comments submitted timely regarding the proposals set forth in this proposed rule and make final the policy and regulations for the revised ASC payment system for implementation effective January 1, 2008. We are proposing to include the CY 2008 ASC payment rates as part of the proposed and final rules for the CY 2008 OPPS update.

We are proposing to evaluate each year all new CPT and alphanumeric HCPCS codes that describe surgical procedures to make preliminary determinations regarding whether or not they should be payable in the ASC setting and, if so, whether they are office-based procedures. In the absence of claims data that would indicate where procedures described by new codes are being performed, and resources required to perform them, we are proposing to use other available information, including our clinical advisors' judgment, predecessor CPT and HCPCS codes, information submitted by representatives of specialty societies and professional associations, and information submitted by commenters during the public comment period following publication of the final rule with comment period in the **Federal Register**. We would publish in the annual OPPS/ASC payment update final rule those interim determinations for the new codes to be active January 1 of the update year. Those procedures would be open to comment on that final rule, and we would respond to comments about our determinations in the final rule for the following year, just as we currently respond to comments about our APC assignments for new codes in the OPPS final rule for the following year. After our review of public comments and in the absence of physicians' claims data, if our determination regarding the new codes is that they should reside on the ASC list as office-based procedures subject to the payment limitation, this determination would remain preliminary until there are adequate physicians' claims data available for these procedures to assess their predominant sites of service. Using those data, if we confirm our determination that the new codes are office-based because they were performed in the physician office setting more than 50 percent of the time, the codes would then be permanently assigned to the list of office-based procedures subject to the payment limitation.

Accordingly, we are proposing to reflect this annual rulemaking and publication of revised payment methodologies and payment rates in new § 416.173 in proposed new subpart F.

D. Information in Addenda Related to the Revised CY 2008 ASC Payment System

(If you choose to comment on issues in this section, please include the caption ''ASC Addenda'' at the beginning of your comment.)

The ASC payment rates, copayment amounts, and relative payment weights displayed in Addendum BB of this proposed rule are presented to model the ratesetting methodology that we are proposing for the revised ASC payment system required by Pub. L. 108–173. Actual payment rates proposed and made final for CY 2008 are dependent upon the final policies and regulations affecting the revised payment system that we would publish in a final rule in CY 2007; the proposed and final APC groups, APC relative payment weights, and MPFS nonfacility practice expense RVUs for CY 2008; and, the ASC conversion factor updated to reflect CY 2006 utilization data and CY 2007 ASC standard overhead payment amounts.

E. Technical Changes to 42 CFR Parts 414 and 416

We are proposing to make the following technical change to 42 CFR 414:

- § 414.22 (Non-facility practice expense RVUs) is revised to conform to changes occurring under the ASC revised payment system. The change will be effective January 1, 2008.

We are proposing to make the following technical changes to 42 CFR 416:

- § 416.65(a)(4) is revised to replace the obsolete cross-reference to § 405.310 with § 411.15.
- § 416.120 is revised by replacing the incorrect cross-reference to ''Part 413'' with ''Part 419.''
- § 416.150 (Beneficiary appeals) is deleted because it does not conform with the appeals process provisions of 42 CFR Part 405, subparts H and I.

XIX. Medicare Contracting Reform Mandate

A. Background

Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108–173, amended Title XVIII of the Act to add section 1874A, Contracts with Medicare Administrative Contractors (MACs). Section 1874A of the Act replaces the prior Medicare intermediary and carrier contracting authorities formerly found in sections 1816 and 1842 of the Act, respectively. This reform (commonly referred to as ''Medicare contracting reform'' for Medicare fee-for-service) is intended to improve Medicare's administrative services to beneficiaries and health care providers and to bring standard contracting principles to Medicare, such as competition and performance incentives, which the government has long applied to other Federal programs under the Federal Acquisition Regulation (FAR). For Department of Health and Human Services acquisitions, the FAR is supplemented by the Department of Health and Human Services Acquisition Regulation (HHSAR) (48 CFR chapter 3). Using

competitive procedures, CMS will replace its current claims payment contractors (intermediaries and carriers) with new contract entities, MACs. Section 911(d)(1)(C) of Pub. L. 108–173 requires that CMS compete and transition all Medicare claims processing workloads to MACs by October 1, 2011.

In accordance with section 911(e) of Pub. L. 108–173, on or after October 1, 2005, any reference to an ''intermediary'' or ''carrier'' in a regulation shall be deemed a reference to a MAC. The process of transition from intermediaries and carriers to MACs is not a single point-in-time occurrence, but rather necessarily happens over a multiyear period due to the size and nature of the claims workloads involved. Therefore, for the purposes of clarity, the term ''intermediary'' is used throughout this proposed rule to describe a Medicare contractor, pursuant to the authority of section 1816 of the Act, that has not yet transitioned to a MAC. In addition, for the purpose of clarity, the term ''carrier'' is used throughout this proposed rule to describe a Medicare contractor, pursuant to the authority of section 1842 of the Act, that has not yet transitioned to a MAC.

B. CMS' Vision for Medicare Fee-for-Service and MACs

CMS' vision for the Medicare fee-for-service (FFS) program is that of a premier health plan that allows for comprehensive, quality care and world-class beneficiary and provider service. Achieving this vision requires substantial improvement of CMS' current FFS administrative structure. Further information on CMS' plans to improve Medicare FFS may be obtained through the Medicare Contracting Reform Web site: *http://www.cms.hhs.gov/medicarereform/contractingreform/.*

In 2006, there are 24 intermediaries and 17 carriers that process FFS claims. Intermediaries process claims for Medicare Parts A and B relating to services furnished by health care facilities, including hospitals and SNFs. Carriers process claims for Medicare Part B, in particular, for physician, laboratory, and other nonfacility services. In addition, 4 intermediaries serve as regional home health intermediaries (RHHIs) and process Medicare claims for home health services and hospice services. (Section 1816 of the Act was amended in 1977 to allow the Secretary to designate regional or national intermediaries, which we refer to as RHHIs, to process claims for home health services. We have designated these RHHIs to serve both the home health agency (HHA) and the hospice provider communities.) For a complete listing of the current Medicare intermediaries and carriers, refer to the CMS Web site: *http://www.cms.hhs.gov/contacts/incardir.asp*.

Although health care delivery in the United States has evolved with advances in modern technology, the contracting authorities relating to the Medicare FFS administrative structure did not substantially evolve between the enactment of the Medicare statute in 1965 and the enactment of Pub. L. 108–173.

Prior to passage of Pub. L. 108–173, intermediary and carrier acquisition authorities did not permit full and open competition or unified processing of Medicare Part A and Part B claims. Medicare contracting was significantly hampered by the absence of performance-based incentives and cumbersome termination procedures.

In an effort to achieve Congress' goal of a more efficient and effective Medicare operation, CMS developed a plan for most current Medicare Part A and Part B intermediary and carrier responsibilities to be integrated into a single contract entity to be administered by a single contractor in each area of the country. These new MACs will handle claims processing and related activities traditionally performed by intermediaries and carriers.

Under Medicare contracting reform, the MACs will perform all the core claims processing operations for both Medicare Part A and Part B. CMS will ensure that MACs focus on providing a high level of customer service to providers and beneficiaries. MACs will be the providers' primary contact with Medicare, and CMS will hold the MACs accountable for overall provider and beneficiary satisfaction and correct claims payment.

With respect to financial management, as was required of intermediaries and carriers, MACs will promote the fiscal integrity of the program and be accountable stewards of the Medicare Trust Fund dollars. The MACs will be required to pay claims timely, accurately, and in a reliable manner while promoting cost efficiency and the delivery of maximum value to the program.

We recognize the potential for improving the efficiency and effectiveness of services to Medicare beneficiaries and providers through the Medicare contracting reform provisions contained in section 1874A of the Act. Through our implementation of these provisions, we expect to realize significant performance improvements. The future environment is designed to generate substantial savings both from an administrative and programmatic standpoint and will safeguard CMS' mission.

C. Provider Nomination and the Former Medicare Acquisition Authorities

As originally enacted in 1965 and until the enactment of Pub. L. 108–173, section 1816 of the Act afforded groups or associations and individual providers of services (as defined at section 1861(a) of the Act) the right to nominate (appoint) their intermediary. The intermediary agreements were governed by Medicare laws that diverge from the FAR in a number of important respects. Prior to Public Law 108–173, section 1816 of the Act precluded the Medicare program from competing intermediary functions on a full and open basis. Rather, institutional providers of services, such as hospitals and nursing facilities, nominated a particular intermediary to process and pay their Medicare Part A claims.

In a significant historical development that took place shortly after Medicare's enactment in 1965, the American Hospital Association and other provider trade associations nominated the Blue Cross Association (BCA) to serve as the intermediary for their membership. The BCA merged with the Blue Shield Association in the 1970s to form today's Blue Cross and Blue Shield Association (BCBSA.) CMS and the BCBSA then entered into a prime contract, which continues to currently exist through the annual renewal process. In turn, the BCBSA subcontracted most operational intermediary functions to its member plans. The BCBSA assigned the majority of the nation's hospitals to its local Blue Cross plans. Some providers of services nominated commercial insurers to serve as their intermediaries.

Most recently, section 911(b) of Pub. L. 108–173 amended section 1816 of the Act to remove the provider nomination authority. The section has been renamed: ''Provisions Relating to the Administration of Part A.'' Section 1816(a) of the Act, which authorized providers to select a contractor to perform claims payment and audit functions, has been amended. It now contains one sentence mandating the use of contracts with MACs to administer section 1816 of the Act. Sections 1816(e), (f), and (g), which authorized the Secretary to develop standards, criteria, and procedures for the assignment of providers to intermediaries and to reassign providers periodically, have been repealed.

Section 911(d) of Pub. L. 108–173 permits the Secretary to transition the current intermediary and carrier functions to the MACs. More information about CMS' plans to implement Medicare contracting reform, including the Report to the Congress on this subject, can be obtained at the CMS Web site: *http://www.cms.hhs.gov/medicarereform/contractingreform/*. MACs will perform all core claims processing operations for both Medicare Part A and Part B. The Part A and Part B MACs will operate in distinct, nonoverlapping geographic jurisdictions, which will form the basis of the Medicare claims processing operations. A transitional period runs between October 1, 2005, and October 1, 2011. During this period, any existing intermediary and carrier contracts could be maintained until replaced by a MAC contract. The statute requires that all intermediary and carrier contract functions are to be competed and awarded as MAC contracts by October 1, 2011.

D. Summary of Changes Made to Section 1816 of the Act

Substantial changes to section 1816 of the Act that were required by sections 911(b) and 911(c) of Pub. L. 108–173 took effect on October 1, 2005. The changes that we are proposing in this proposed rule to the regulations under 42 CFR part 421, subpart B (discussed under section XIX.E. of this preamble) are intended to conform the regulations to these statutory changes.

Prior to the statutory developments directed by Pub. L. 108–173, section 1816 of the Act provided the foundation acquisition authority for agreements between CMS, acting for the Secretary, and intermediaries, for the purpose of administering benefits under Medicare Part A and making payments to providers of services.

In particular, section 1816(a) of the Act formerly gave groups and associations of providers of services (which, under section 1861(u) of the Act, includes hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), HHAs, hospices, and, for the purposes of sections 1814(g) and 1835(e) of the Act, funds) the power to nominate their servicing intermediary to determine and make Medicare payments to their members. Under this provision, an intermediary could be a ''national, state, or other public or private agency or organization.'' As previously stated, under this provision, the American Hospital Association nominated the national Blue Cross Association to serve as the prime Medicare intermediary for its membership in 1965, an arrangement that continues to exist.

Moreover, prior to the enactment of Pub. L. 108–173, section 1816(d) of the Act allowed individual providers and groups of providers to—

- Part with their group or association and nominate another entity to serve as their intermediary; and
- Withdraw its/their nomination from an intermediary, and obtain services from another intermediary that had an agreement with the Secretary.

Finally, section 1816(e) of the Act, as it formerly read, specified the substantial procedural requirements to be followed by the Secretary in the event that the Secretary desired to assign or reassign individual providers of services to any intermediary other than the nominated entity. This provision also gave limited authority to the Secretary to designate a regional or national intermediary for a particular ''class'' of providers of services. However, this authority was subject to substantial procedural requirements. Among these procedural requirements were:

- The Secretary had to promulgate standards, criteria and procedures for evaluating the performance of intermediaries under section 1816(f) of the Act;
- The Secretary had to make a finding, after applying such standards, criteria, and procedures, that the reassignment of the individual provider and/or the designation of the regional or national intermediary would result in more efficient and effective administration of the Medicare program;
- The Secretary had to provide a full explanation of his reasons for determining that the intermediary change would result in more efficient and effective administration; and
- Affected agencies and organizations were given the right to a hearing, and any determinations of the Secretary on nominations and provider assignments were subject to judicial review.

In the former sections 1816(e)(4) and 1816(e)(5) of the Act, the Secretary was given authority to establish regional intermediaries with respect to HHAs and hospice providers, although certain procedural requirements still had to be met.

In summary, while under section 1816 of the Act, the Secretary was not required to accept all Medicare intermediary nominations, the Secretary had no independent authority to contract with any entity for Medicare intermediary services outside the nomination process. Moreover, while providers of services were given the opportunity to seek a reassignment to a new intermediary, the Secretary could not assign or reassign individual providers or classes of providers unless substantial procedural requirements were followed.

The existing Medicare regulations under 42 CFR Part 421, particularly those within Subparts A and B, were substantially shaped by this statutory framework relating to provider nominations and the assignment or reassignment of providers of services to intermediaries. In particular, the following regulatory provisions have their basis in the statutory provisions of sections 1816(a), (d), and (e) of the Act (all are located within 42 CFR Part 421):

- § 421.1(c), which discusses criteria to be used in assigning and reassigning providers;
- § 421.3, which provides exceptions to definitions to accommodate the designation of regional intermediaries for HHAs and intermediaries for hospices;
- § 421.103, which identifies options available to providers for receiving Medicare payments;
- § 421.104, which provides the procedural framework governing the administration of provider nominations for intermediaries;
- § 421.105, which obligates CMS to provide notice as to its action on nominations;
- § 421.106, which specifies the process to be used by a provider desiring a change of intermediary;
- § 421.112, which provides the considerations to be taken into account by CMS when, among other things, it desires to assign or reassign a provider to an intermediary or designate a regional or national intermediary for a class of providers;
- § 421.114, which governs the assignment or reassignment of individual providers;
- § 421.116, which specifies the requirements for designating national or regional intermediaries consistent with sections 1816(e)(1) through (e)(3) of the Act; and
- § 421.117, which specifies the parameters for assigning HHAs and hospice providers to regional intermediaries consistent with sections 1816(e)(4) and (e)(5) of the Act.

In addition to the provisions discussed above that relate to provider nominations, prior to the enactment of Pub. L. 108–173, section 1816 of the Act also contained other provisions governing agreements with Medicare intermediaries that were not consistent with the mainstream of Federal acquisition and procurement

authorities, as this mainstream is reflected in the FAR. For instance—

- Section 1816(b) of the Act contains provisions that limited payment under all intermediary agreements to a cost-reimbursement basis only;
- Section 1816(f) of the Act required the Secretary to publish his performance criteria and standards for intermediary agreements in the **Federal Register**, and specified requirements relating to the application of such criteria and standards; and
- Section 1816(g) afforded intermediaries the right to terminate their agreements with CMS, but limited the right of the Secretary to terminate the agreement; in particular, no provision was made for the normal right of the government to terminate for convenience.

In section 911(b) of Pub. L. 108–173, Congress reiterated the requirement that CMS begin to move beyond the legacy nomination-based intermediary agreements during FY 2006. This was done by repealing outright or substantially modifying many of the provisions of section 1816 of the Act, effective October 1, 2005. In particular, section 911(b) of Pub. L. 108–173—

- Repealed the prior language of section 1816(a) of the Act, including the basic provider nomination provision, and replaced it with a statement indicating that Medicare Part A administrative functions would be contracted through section 1874A of the Act;
- Repealed section 1816(b) of the Act in full, including its provisions limiting payment to cost reimbursement;
- Repealed the contract-related provisions of section 1816(c) of the Act;
- Repealed sections 1816(d), (e), (f), (g), (h), (i), and (l) of the Act; and
- Made conforming changes to sections 1816(c), (j), and (k) of the Act.

With these changes, section 1816 of the Act is no longer an acquisition authority, and there is no vestige of the former provider nomination provisions or the partial exceptions to those provisions relating to home health and hospice providers.

While section 911(d)(1)(B) of Pub. L. 108–173 allows the Secretary to continue intermediary and carrier contracts in effect prior to October 1, 2005, under their terms and conditions until October 1, 2011, there was no similar extension for existing nomination arrangements. Section 911(d)(2)(A) of Pub. L. 108–173 provides the Secretary with authority to enter into intermediary agreements outside of the provider nomination process starting with the date of enactment of Pub. L. 108–173 (December 8, 2003). Therefore, while Congress specified that the Secretary should submit his plan for implementing section 911 at the start of FY 2005, the Secretary was authorized to contract outside of the section 1816 nomination provisions immediately and in advance of delivery of his report. This analysis requires that similar, conforming changes be made in our regulations as set forth in this proposed rule.

E. Provisions of the Proposed Regulations

As discussed under section XIX.A. of this preamble, based on the authority provided in sections 1874A(a) through (d) of the Act, as established by section 911(a)(1) of Pub. L. 108–173, we are proposing to establish regulations pertaining to MACs in a new Subpart E of 42 CFR Part 421. Moreover, based on the substantial changes to section 1816 of the Act, including the repeal of all of the section 1816 provisions relating to the ability of providers to nominate their servicing intermediary, as enacted by section 911(b) of Pub. L. 108–173, we also are proposing a number of changes to Subparts A and B of 42 CFR Part 421. In addition, we are proposing to change the title of Part 421 from ''Intermediaries and Carriers'' to ''Medicare Contracting'' and make conforming revisions to Subpart B of Part 421.

As discussed earlier, section 911(b) of Pub. L. 108–173 either repealed outright or substantially modified sections 1816(a), (b), (c), (d), (e), (f), (g), (h), (i), and (l) of the Act, and made clear that the acquisition authority for Part A claims processing would, after October 1, 2005, be found in section 1874A of the Act. Among all these changes, each of the former ''provider nomination'' provisions within section 1816 of the Act was repealed. In addition, section 911(d)(2)(A) of Pub. L. 108–173 gave the Secretary authority to disregard the provider nomination provisions in his contracting, even prior to October 1, 2005. In accordance with these statutory changes, we are proposing to substantially modify or delete §§ 421.1(c), 421.3, 421.103, 421.104, 421.105, 421.106, 421.112, 421.114, 421.116, and 421.117 of the regulations.

As discussed earlier, the amendment to title XVIII of the Act (to allow for the new section 1874A: ''Contracts with Medicare Administrative Contractors'') requires CMS to contract with eligible entities to perform Medicare functions using the FAR. We are proposing to add regulations pertaining to MAC contracts in a new subpart E (Medicare Administrative Contractors) under Part 421 as follows:

Subpart E—Medicare Administrative Contractors

Sec.
421.400 Basis and scope.
421.401 Definitions.
421.404 Assignment of providers and suppliers to MACs.

1. Definitions

Under proposed § 421.401, we define a ''Medicare administrative contractor (MAC)'' as an agency, organization, or other person with a contract to perform any or all of the functions set forth under section 1874A of the Act. With respect to the performance of a particular function in relation to an individual entitled to benefits under Medicare Part A or enrolled under Medicare Part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), we are proposing to define an ''appropriate MAC'' as a MAC that has a contract to perform a Medicare administrative function in relation to a particular individual, provider of services, or supplier or class of providers.

2. Assignment of Providers and Suppliers to MACs

We are proposing to establish a new § 421.404 to incorporate the rules governing the processing of claims submitted by providers and suppliers that enroll with and receive Medicare payment and other Medicare services. As a general rule, Medicare providers and suppliers will be assigned to the MAC that is contracted to administer the types of services (benefits) billed by the provider or supplier within the geographic locale in which the provider or supplier is physically located or furnishes health care services, respectively. One significant exception to this general rule pertains to suppliers of durable medical equipment, prosthetics, orthotics, and supplies. CMS would continue to allow these suppliers to bill to the contractor assigned to the locale in which the beneficiary receiving the items or supplies resides.

In the past, under the provider nomination provisions that were repealed by section 911 of Pub. L. 108–173, CMS had considered (and occasionally approved) requests from certain classes of institutional providers covered by these section 1816 provisions, primarily, hospitals, SNFs, and CAHs, to bill an intermediary other than the one servicing providers in the geographic locale of the provider. The

process and criteria for making these determinations are set forth in detail in the existing regulations under 42 CFR part 421, subpart B (which we are proposing to remove in accordance with the changes effectuated by section 911(b) of Pub. L. 108–173.

In particular, not automatically but on a fairly frequent basis, CMS approved requests from large multi-State groups of such providers under common ownership and control, called ''chain providers,'' to bill a single intermediary on behalf of all the individual providers in the chain through the headquarters office, or ''home office,'' of the chain provider. These chain providers were granted ''single intermediary'' status.

The premise behind granting privileges to bill a single intermediary to such large multi-State chain providers was that this might reduce administrative billing expenses for the chain and reduce the administrative expenses of the Medicare program. In particular, assigning a large multi-State chain provider to a single intermediary facilitated the Medicare cost report audit and reimbursement functions, because findings with respect to the cost report of the chain's home office could affect the individual provider's cost report. Otherwise, these audit and reimbursement issues would need to be coordinated among multiple intermediaries.

In addition to applying the relevant regulatory requirements in 42 CFR part 421, subpart B in our review of chain provider requests for single intermediary status, we applied additional criteria to focus our analysis and to ensure that the exception to our normal practice of assigning providers to their ''local'' intermediary was warranted. We advised the chain provider that it would have to demonstrate that having a single intermediary would be consistent with efficient and effective administration of the Medicare program, and that the intermediary would need to have sufficient capacity to effectively serve the chain (these elements were restatements of the regulatory criteria). In addition, we required the chain to meet the following requirements:

- Size—The provider chain had to be comprised of 10 participating facilities or 500 certified beds, or 5 facilities or 300 certified beds spread across 3 or more contiguous States.
- Central Controls—The provider chain had to demonstrate that it exercised central controls, assuring substantial uniformity in operating procedures, utilization controls, personnel administration, and fiscal operations among the individual providers.

The administrative efficiencies gained by both the large multi-State chain providers and the Medicare program by allowing single intermediary relationships to exist may not be as significant as they were formerly. Prior to the implementation of the Administration Simplification provisions of Part C of Title XI of the Act, the various intermediaries required providers to use somewhat divergent transaction and formatting standards in their electronic claims processing systems. A provider chain with centralized billing processes could make a good business case that it should be permitted to bill only one intermediary. Moreover, prior to the implementation of the many prospective payment systems required by the Balanced Budget Act of 1997 and subsequent public laws, a greater percentage of Medicare program payments hinged on the Medicare cost report audit and reimbursement process. In such an environment, there was potential benefit to both a chain provider and the government to minimize coordination issues. Finally, the former Medicare environment involved many intermediaries, so there were naturally more geographic boundaries among contractors that a multi-State chain could cross.

We understand the provisions of section 1874A of the Act and, more particularly, the revisions to section 1816 of the Act made by section 911(b) of Pub. L. 108–173 to authorize the Secretary to assign all providers and suppliers, even the members of multi-State entities, to the geographically-based MACs based on their physical location. This action is consistent with CMS' vision, as articulated in the Secretary's Report to Congress on Medicare Contracting, of establishing a claims processing environment where most Medicare Part A and Part B claims involving a particular beneficiary are administered by the same contractor.

However, as indicated in that Report (page V–4), we recognize that there may still be some legitimate business value to allowing large multi-State chains of providers that formerly were able to nominate their intermediary to bill on a consolidated basis to one MAC. While Congress has clearly mandated that the former provider nomination framework be abolished, we believe that allowing the practice of consolidated billing by large chains is within the discretion of the Secretary under section 911 of Pub. L. 108–173. Accordingly, in this proposed rule, we are proposing under § 421.404 that—

- Providers (as defined in 42 CFR 400.202) will generally be assigned to the MAC with claims processing jurisdiction over the geographic locale in which the provider is physically located.
- Large chain providers comprised of individual providers that were formerly permitted by CMS to ''nominate'' an intermediary, which we refer to as ''qualified chain providers,'' will be permitted to request opportunity to consolidate their Medicare billing activities to the MAC with jurisdiction over the geographic locale in which the chain's home office is located.
- Qualified chain providers that were formerly granted single intermediary status do not need to re-request such privileges on behalf of the entire chain at this time.
- CMS may grant other exceptions to the general rule for assigning providers to MACs, but only based on a finding that such an exception will support the implementation of the MACs or if CMS deems the exception to be in the compelling interest of the Medicare program.

We are proposing to incorporate a definition of ''qualified chain provider.'' The criteria that constitute the proposed definition of a ''qualified chain provider'' mirror the elements that were historically applied. We believe these are appropriate criteria to employ in reviewing whether a chain provider should even be considered for consolidated billing. Less stringent criteria would clearly cut against the statutory mandate to establish MACs and end the provider nomination process. More stringent criteria might disrupt the operations of many entities that formerly were approved for single intermediary handling under the old criteria.

Smaller chains of otherwise eligible providers (for example, hospitals, SNFs, and CAHs) might also desire consolidated billing, as well as other types of providers (for example, HHAs and hospices). In the latter case, the other types of providers (termed ''ineligible providers'' in this proposed rule) did not have the opportunity to request assignment to (nominate) a particular intermediary prior to October 1, 2005. In some cases, these other types of providers were assigned to regional intermediaries based on a nexus of statutory and administrative actions. In other cases, assignments were made through administrative action. In the case of smaller chains of otherwise eligible providers, we note that Pub. L. 108–173 clearly mandates the end of the provider nomination process and

appears to us to anticipate the use of regional contractors.

We believe that our establishment of MACs that, in most cases, will administer claims from multiple States will largely resolve the concerns these other providers may have. Under our proposed approach, for instance, we believe that few chain providers will have to bill more than two MACs even if they fail to meet the tests for being a ''qualified chain provider.''

Finally, with respect to suppliers (as also defined in 42 CFR 400.202 of our regulations), we are proposing to assign suppliers (including physicians and other practitioners) to MACs based on the geographic jurisdiction in which they operate and furnish services. These requirements mirror the various Part B claims jurisdiction rules that have been in place. CMS may grant an exception to this policy only if CMS finds the exception will support the implementation of MACs or will serve some compelling interest of the Medicare program.. However, we do incorporate the current special billing requirements relating to suppliers of durable medical equipment, prosthetics, orthotics, and supplies under § 421.210 and § 421.212.

As we move forward to implement MAC contracting in keeping with the statutory mandate of section 911 of Pub. L. 108–173 and the Secretary's Report to Congress, we invite public comments on the above issues, including our proposed definitions and criteria. (Once the MACs are initially implemented, we may propose more stringent criteria for consolidated billing status, in keeping with the overall thrust of section 911 of Pub. L. 108–173.)

3. Other Proposed Technical and Conforming Changes

a. Definition of ''Intermediary'' (§ 421.3)

We are proposing to revise the definition of the term ''intermediary'' under existing § 421.3 to delete reference to ''alternative regional intermediaries.'' CMS no longer allows HHAs and hospice care providers to select an alternative regional intermediary. Over the years, as the number of intermediaries in the program has decreased, the availability of alternative intermediaries for HHAs and hospices has declined. We have implemented the policy that all HHAs and hospice care facilities are to be assigned to the designated regional intermediary that serves their geographic jurisdiction. This is required for the efficient and effective administration of the Medicare program as the agency moves forward to implement the MACs.

b. Intermediary Functions (§ 421.100)

Section 1816(a) of the Act, which allowed providers to nominate an intermediary, required that only nominated intermediaries perform the functions of determining payment amounts and making payments to providers. Section 1874A of the Act, as added by section 911 of Pub. L. 108–173, eliminates the intermediary nomination process. All activities carried out under intermediary agreements will be transitioned to MAC contracts by September 30, 2011.

During the transition period, CMS will still require regulations to support its intermediary agreements. We are proposing to amend § 421.100, concerning functions to be included in intermediary agreements, to address the dual intermediary responsibilities.

We are proposing to revise existing § 421.100(i), Dual intermediary responsibilities, to delete the reference to § 421.117 from this section, as the statutory provision that made this necessary was repealed by Pub. L. 108–173.

c. Options Available to Providers and CMS (§ 421.103)

We are proposing to change the title of § 421.103 to ''Payment to Providers'' and to revise the contents of § 421.103 to clarify that, all providers must receive payments for covered services furnished to Medicare beneficiaries through an intermediary (under § 421.404) and eventually through a MAC (under § 421.404). We are proposing that this function must remain with the intermediaries. We would no longer allow providers to receive payments directly from CMS, nor would we allow providers to receive payments from alternative regional intermediaries. We believe the inclusion of this function is consistent with the effective and efficient administration of the Medicare program.

d. Nomination for Intermediary (§ 421.104)

We are proposing to change the title of § 421.104 to ''Assignment of Providers of Services to Intermediaries During Transition to Medicare Administrative Contractors (MACs)'' and to revise the contents of the section to provide that new providers that enter the Medicare program during the transition period will be assigned to the local designated intermediary that serves the jurisdiction in which the provider is located. We believe this change is necessary as we prepare to transition from intermediary agreements and carrier contracts to contracts with the MACs. In the MAC environment, providers will be assigned based on their geographic location to the MAC that has jurisdiction for their provider type.

e. Notification of Actions on Nominations, Changes to Another Intermediary or to Direct Payment, and Requirements for Approval of an Agreement (§ 421.105 and § 421.106)

We are proposing to remove § 421.105 and § 421.106 from the regulations, as the sections would no longer be applicable with implementation of the new Subpart E.

f. Considerations Relating to the Effective and Efficient Administration of the Medicare Program (§ 421.112)

We are proposing to revise § 421.112(a). As stated previously in this proposed rule, provider requests to be assigned or reassigned to a particular intermediary will no longer be considered. However, we may deem it necessary to reassign providers if we find it is necessary for the efficient and effective administration of the program. In addition, there will no longer be a national intermediary to serve a class of providers.

g. Assignment and Reassignment of Providers by CMS (§ 421.114)

We are proposing to revise § 421.114 to specify that we may consider it necessary to assign and reassign providers if the assignment or reassignment is in the best interest of the program. Before making these determinations, we will no longer review provider requests to be reassigned to another intermediary. This is consistent with the proposed policy to eliminate a provider request to change to another intermediary or to direct payment. Under Medicare contracting reform, we require increased flexibility to realign providers to geographical jurisdictions for effective implementation of the MACs. We reserve the right to reassign providers to other jurisdictions if we deem it to be in the best interest of the program.

h. Designation of National or Regional Intermediaries (§ 421.116) and Designation of Regional and Alternative Designated Regional Intermediaries for Home Health Agencies and Hospices (§ 421.117)

We are proposing to delete § 421.116, Designation of national or regional intermediaries, and § 421.117, Designation of regional and alternative designated regional intermediaries for

HHAs and hospices. The statutory provisions that made these regulations necessary were repealed by Pub. L. 108–173. Therefore, we no longer need these regulations. All providers will receive payment for covered services as described in § 421.103.

i. Awarding of Experimental Contracts (§ 421.118)

We are proposing to delete § 421.118, which specifies the provisions under which CMS may award a fixed price or performance incentive contract under the experimental authority contained in 42 U.S.C. 1395b–1 for performance of intermediary functions under § 421.100. The provisions of this section became obsolete with the enactment of section 911 of Pub. L. 108–173.

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

(If you choose to comment of issues in this section, please include the caption ''Hospital Quality Data'' at the beginning of your comment.)

As noted previously, CMS' Office of the Actuary currently projects that Medicare Part B expenditures will continue to grow at a significant rate, as a result of rapid growth in the use of both physician-related services and hospital outpatient services in the original Medicare fee-for-service program. Specifically, the actuaries project that the expenditures under the OPPS in CY 2007 will be approximately $32.540 billion. This represents approximately a 9.2 percent increase over our estimated expenditure of $29.809 billion for the OPPS in CY 2006, and reflects even more rapid spending growth in recent years. As the following table shows, implementation of the OPPS has not slowed outpatient spending growth; in fact, double-digit spending growth has been occurring.

TABLE 47.—GROWTH IN EXPENDITURES UNDER OPPS FROM CY 2001 THROUGH CY 2007 (PROJECTED EXPENDITURES FOR CY 2006 AND CY 2007)

[in millions]

OPPS growth	CY 2001	CY 2002	CY 2003	CY 2004	CY 2005	CY 2006	CY 2007
Incurred Cost	19,172	19,561	21,146	23,912	26,643	29,809	32,540
Percent Increase	.....	2.0	8.1	13.1	11.4	11.9	9.2

Source: FY 2007 Mid-Session Review, Budget of the U.S. Government.

The current rate of growth in expenditures for hospital outpatient services is of great concern to us. As with the other Medicare fee-for-service payment systems that are experiencing rapid spending growth, brisk growth in the intensity and utilization of services is the primary reason for the current rate of growth in the OPPS, rather than general price or enrollment changes. The table below illustrates the increases in the volume and intensity of outpatient hospital services over the last several years.

TABLE 48.—PERCENT INCREASE IN VOLUME/INTENSITY OF HOSPITAL OUTPATIENT SERVICES

	CY 2002	CY 2003	CY 2004	CY 2005 (Est.)	CY 2006 (Est.)
Percent Increase	3.0	2.0	8.0	8.0	10.0

Source: FY 2007 Mid-Session Review, Budget of the U.S. Government.

For outpatient hospital services, the volume and intensity for CY 2005 are estimated to continue to increase significantly at a rate of 8 percent, in excess of the long-term trend. This increase follows the 8 percent increase in CY 2004, and the growth is projected to be 10 percent in CY 2006.

As we have stated repeatedly, this rapid growth in utilization of services in the OPPS shows that Medicare is paying mainly for more services each year, regardless of their quality or impact on beneficiary health. The program should promote higher quality services, so that Medicare spending is directed in the most efficient manner toward higher quality services. Medicare payments should encourage doctors and other providers in their efforts to achieve better health outcomes for Medicare beneficiaries at a lower cost. Therefore, we have been examining the concept of ''value-based purchasing'' in a number of payment systems. ''Value-based purchasing'' may use a range of incentives to achieve identified quality and efficiency goals, as a means of promoting better quality of care and more effective resource use in the Medicare payment systems. In developing the concept of value-based purchasing, we have been working closely with stakeholder partners, including health professionals and providers.

In this proposed rule, we are seeking public comment on value-based purchasing as related specifically to hospital outpatient departments. As part of our overall goal of promoting value-based purchasing in outpatient payment, we also make one specific proposal in the OPPS for CY 2007.

Section 1833(t)(2)(E) of the statute permits the Secretary to ''establish, in a budget neutral manner, * * * adjustments as determined to be necessary to ensure equitable payments'' under the OPPS. The absence of OPPS measures to promote high quality in the provision of services to Medicare beneficiaries creates an issue of payment equity. In general, payments to providers in Medicare's payment systems do not vary on the basis of quality or efficiency differences among the providers of services. As a result, Medicare's payment systems direct additional resources to hospitals that deliver care that is not of the highest quality. For that reason, each Medicare dollar spent does not result in the same quality and efficiency of care for Medicare beneficiaries.

We believe that the collection and submission of performance data and the public reporting of comparative information about hospital performance can provide a strong incentive to encourage hospital accountability in general and quality improvement in particular. Measurement and reporting can focus the attention of hospitals and consumers on specific goals and on

hospitals' performance relative to those goals. Development and implementation of performance measurement and reporting by hospitals can thus produce quality improvement in actual health care delivery. Hospital performance measures may also provide a foundation for performance-based rather than volume-based payments, which are used in the OPPS today.

We have obtained some evidence of the potential for improving quality of care in hospitals by means of the collection and submission of performance data from the Premier Hospital Quality Incentive Demonstration.[1] This demonstration was designed to test whether the quality of inpatient care for Medicare beneficiaries can improve when financial incentives are provided. Under the demonstration, about 270 hospitals of Premier, Inc., a nationwide alliance of not-for-profit hospitals, have been voluntarily providing data on 34 quality measures related to 5 clinical conditions: Heart attack, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. Using the quality measures, CMS identifies hospitals with the highest quality performance in each of the five clinical areas. Hospitals scoring in the top 10 percent in each clinical area receive a 2-percent bonus payment in addition to the regular Medicare DRG payment for the measured condition. Hospitals in the second highest 10 percent receive a 1-percent bonus payment. In the third year of the demonstration, if some hospitals do not achieve absolute improvements above the demonstration's first year composite score baseline (the lowest 20 percent) for that condition, then they will have their DRG payments reduced by one or two percent, depending on how far their performance is below the baseline.

Following the first year of the demonstration (FY 2004), CMS awarded a total of $8.85 million to participating hospitals in the top two deciles for each clinical area. In the aggregate, quality of care improved in all five clinical areas that were measured. Preliminary information from the second year of the demonstration indicates that quality is continuing to improve, particularly for the hospitals that were initially poorest performing.[2] We believe that these results indicate that reporting of quality data may in and of itself lead to improved outcomes for Medicare beneficiaries.

Since 2003, we have operated the Hospital Quality Initiative,[3] which is designed to stimulate improvements in inpatient hospital care by standardizing hospital performance measures and data transmission to ensure that all payers, hospitals, and oversight and accrediting entities use the same measures when publicly reporting on hospital performance. Section 501(b) of Pub. L. 108–173 authorized us to link the collection of data for an initial starter set of 10 quality measures to the hospital IPPS annual payment update. In order to implement this provision, we created the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. For FYs 2005 and 2006, hospitals that met the RHQDAPU program's requirements received the full IPPS annual payment update, while hospitals that did not comply received an update that was reduced by 0.4 percentage points. For FY 2005, virtually every hospital in the country that was eligible to participate submitted data (98.3 percent), and approximately 96 percent of all participating hospitals met the requirements to receive the full update. The data regarding the starter set of 10 quality measures, as well as additional, voluntarily-reported data on other quality measures, are available to the public through the Hospital Compare Web site at: *http://www.hospitalcompare.hhs.gov.*

The starter set of 10 quality measures that was established for the IPPS RHQDAPU as of November 1, 2003, are:

Heart Attack (Acute Myocardial Infarction/AMI)

- Was aspirin given to the patient upon arrival to the hospital?
- Was aspirin prescribed when the patient was discharged?
- Was a beta-blocker given to the patient upon arrival to the hospital?
- Was a beta-blocker prescribed when the patient was discharged?
- Was an ACE inhibitor given for the patient with heart failure?

Heart Failure (HF)

- Did the patient get an assessment of his or her heart function?
- Was an ACE inhibitor given to the patient?

Pneumonia (PNE)

- Was an antibiotic given to the patient in a timely way?
- Had the patient received a pneumococcal vaccination?
- Was the patient's oxygen level assessed?

For FY 2007 and each subsequent year, section 5001(a) of Pub. L. 109–171 amended section 1886(b)(3)(B) of the Act and made changes to the program established under section 501(b) of Pub. L. 108–173. These changes require us to expand the number of measures for which data must be submitted, and to change the percentage point reduction in the annual payment update from 0.4 percentage points to 2.0 percentage points for IPPS hospitals that do not report the required quality measures in a form and manner, and at a time, specified by the Secretary.

Effective for payments beginning with FY 2007, new section 1886(b)(3)(B)(viii)(IV) of the Act requires the Secretary to begin to adopt the expanded set of performance measures set forth in the IOM's 2005 report entitled, ''Performance Measurement: Accelerating Improvement.''[4] Those measures include the HQA measures and the HCAHPS® patient perspective survey. Effective for payments beginning with FY 2008, the Secretary must add other measures that reflect consensus among affected parties and may replace existing measures as appropriate. New section 1886(b)(3)(B)(viii)(VII) of the Act requires the Secretary to post hospital quality data on these measures on the CMS Web site. A proposed list of expanded quality measures to be used for the FY 2007 update was included in the FY 2007 IPPS proposed rule (71 FR 24093). The final expanded set of 21 quality measures for the FY 2007 update, as listed in the FY 2007 IPPS final rule, is outlined below:

Heart Failure (Acute Myocardial Infarction/AMI)

- Aspirin at arrival
- Aspirin prescribed at discharge
- ACE inhibitor (ACE–I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction
- Beta blocker at arrival
- Beta blocker prescribed at discharge
- Thrombolytic agent received within 30 minutes of hospital arrival
- Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival

[1] The Premier Hospital Quality Incentive Demonstration was authorized under section 402 of Pub. L 90–248, Social Security Amendments of 1967 (42 U.S.C. 1395b–1). This section authorizes certain types of demonstration projects that waive compliance with the regular payment methods used in the Medicare program.

[2] Additional information on the Premier Hospital Quality Incentive Demonstration is available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalQualityInits/35_HospitalPremier.asp.*

[3] Additional information on CMS' Hospital Quality Initiative is available on the CMS Web site at: *http://www.cms.hhs.gov/HospitalQualityInits/.*

[4] Institute of Medicine, ''Performance Measurement: Accelerating Improvement,'' December 1, 2005, available at *http://www.iom.edu/CMS/3809/19805/31310.aspx.*

- Adult smoking cessation advice/counseling

Heart Failure (HF)

- Left ventricular function assessment
- ACE inhibitor (ACE–1) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction
- Discharge instructions
- Adult smoking cessation advice/counseling

Pneumonia (PNE)

- Initial antibiotic received within 4 hours of hospital arrival
- Oxygenation assessment
- Pneumococcal vaccination status
- Blood culture performed before first antibiotic received in hospital
- Adult smoking cessation advice/counseling
- Appropriate initial antibiotic selection
- Influenza vaccination status

Surgical Care Improvement Project (SCIP)

- Prophylactic antibiotic received within 1 hour prior to surgical incision
- Prophylactic antibiotics discontinued within 24 hours after surgery end time

In order to receive the full FY 2007 IPPS update, hospitals are required to continue to collect data for all 10 starter set quality measures (or begin collecting such data, if newly participating in the program) and are required to provide a written pledge to submit data on the set of 21 expanded quality measures, in addition to completing several administrative tasks regarding quality reporting. All of the measures for the IPPS RHQDAPU program are to be reported on inpatient hospital discharges.

We are proposing to employ our equitable adjustment authority under section 1833(t)(2)(E) of the Act to adapt the quality improvement mechanism provided by the IPPS RHQDAPU program for use in the OPPS. As we have discussed above, failure to account at all for quality in payment systems raises a fundamental issue of payment equity. In the absence of mechanisms that provide incentives for higher quality care, Medicare's payment systems can direct more resources to hospitals that do not deliver high quality care to Medicare beneficiaries.

In this rule, we are proposing to initiate a Reporting Hospital Quality Data for Annual Payment Update under the OPPS, (OPPS RHQDAPU program) effective for payments beginning January 1, 2007. We propose to add a new § 419.43(h) to our regulations to implement this proposal. Under proposed new § 419.43(h)(1), we would initially implement an OPPS RHQDAPU program by reducing the OPPS conversion factor update in CY 2007 for those hospitals that are required to report quality data under the IPPS RHQDAPU program in order to receive the FY 2007 update, and fail to meet the requirements for receiving the full FY 2007 IPPS payment update. These hospitals would receive an update to the CY 2007 OPPS conversion factor that is reduced by 2.0 percentage points. Under proposed § 419.43(h)(2), any reduction would not affect a hospital's OPPS update in a subsequent calendar year. Hospitals that meet the IPPS RHQDAPU program's requirements for FY 2007 and receive the full IPPS annual payment update would also receive the full update to the conversion factor used to determine payments for CY 2007 under the OPPS.

For this initial phase of implementing an OPPS RHQDAPU program in CY 2007, it will be necessary to provide an exception for certain hospital outpatient departments to the requirement that quality data be submitted under the IPPS RHQDAPU program in order to receive the full OPPS update. The quality data submission requirements of the IPPS RHQDAPU program apply only to ''subsection (d)'' hospitals. ''Subsection (d)'' hospitals are defined under section 1886(d)(1)(B) of the Act as hospitals that are located in the fifty states or the District of Columbia other than those categories of hospitals or hospital units that are specifically excluded from the IPPS, including psychiatric, rehabilitation, long-term care, children's, and cancer hospitals or hospital units. In other words, the provision does not apply to hospitals and hospital units excluded from the IPPS, or to hospitals located in Puerto Rico or the U.S. territories. For the initial stage of implementing the OPPS RHQDAPU program in CY 2007, hospitals that are paid under the OPPS but that do not qualify as ''subsection (d)'' hospitals will continue to receive the full update to the OPPS conversion factor. However, as we discuss below, our intention is to expand the OPPS RHQDAPU in the future program by requiring all hospitals that receive payment under the OPPS to participate in the program in order to receive a full update, by appropriate expansion, adaptation, and/or extension of quality performance measures and quality reporting mechanisms.

We believe that it is fair and appropriate, for purposes of the initial phase of implementing an OPPS RHQDAPU program, to take timely and accurate reporting of IPPS RHQDAPU program quality measures into account under our equitable adjustment authority. We think that the 10 original quality measures and the expanded set of 21 process measures as reported for inpatient discharges for heart attack, heart failure, pneumonia, and surgical care reflect the quality of care in the outpatient department as well as the inpatient hospital, so they are appropriate for initial use in the OPPS as specific measures are being developed to reflect the quality of care for hospital outpatients. We believe that hospitals generally function as integrated systems that provide health care services to patients in both inpatient and outpatient settings for many of the same clinical conditions, while recognizing the different typical levels of acuity in the two settings. Hospital quality measures for multiple conditions reflect, in part, the systems of care established by hospitals in the outpatient setting such as the emergency department. Therefore, the well-developed quality measures reported for the FY 2007 IPPS regarding inpatient hospital discharges should reasonably represent the quality of care provided to hospital outpatients, so we are proposing their interim use for the CY 2007 OPPS while quality measures specific to hospital outpatients are being developed and refined. This use of multiple measures for several clinical conditions serves as a proxy for the quality of the systems of care established by hospitals. As we expand quality measurement for the hospital outpatient setting, we intend to move from measures that serve as proxies for the quality of care to actual performance measures for the outpatient setting. The discussion below focuses on the expanded list of 21 quality of care measures, as the 10 original measures continue to be included in the quality measurement expansion.

There are 7 quality measures assessing the processes of care for patients presenting to the hospital with an acute myocardial infarction, focused on the care on arrival, the promptness of interventions, and discharge care. For the common urgent condition of a patient presenting to the hospital with chest pain that results in a clinical suspicion of acute myocardial infarction, in their effort to provide consistent, high quality care that is founded on evidence-based guidelines, hospitals often utilize clinical care pathways that are standardized for such patients presenting to the emergency room of the hospital. Such care pathways generally apply to patients with specific medical conditions who

present to the hospital initially as outpatients, regardless of their eventual discharge home from the outpatient department or inpatient admission. Thus, we believe that all 7 of these measures likely serve as reasonable proxies for the quality of care for patients presenting to the hospital outpatient department with chest pain related to a myocardial infarction, who commonly receive care along the continuum from outpatient to inpatient services in a hospital that provides such care in an integrated system.

Similarly, there are 7 process measures related to the care of patients with pneumonia, who often present urgently to the hospital's emergency room with symptoms suggestive of the diagnosis of pneumonia. Because of the established clinical evidence regarding assessment and treatment activities that improve the quality of care for patients with pneumonia, most of the interventions that are measured, including oxygenation assessment, drawing of blood cultures, assessment of the patient's pneumococcal and influenza vaccine status, and selection and provision of an initial antibiotic in a timely manner, would generally be performed in the outpatient department, sometimes prior to a clinical decision about the patient's ultimate need for inpatient admission. In particular, the measures of vaccine status are quality measures that may be especially appropriate as hospital outpatient prevention measures. Their use in the hospital setting provides an opportunity for quality improvement in the hospital by encouraging assessment of immunization status and appropriate provision of immunizations, so we see no reason why their reporting on hospital inpatients is not also reflective of the quality of hospital outpatient care. While we acknowledge that in general the clinical picture of patients who are admitted to the hospital with pneumonia differs from that of patients who are not hospitalized, we expect there to be many common elements in their assessment, treatment, and counseling regarding the significance of smoking as the hospital provides their initial and subsequent care in the outpatient and/or inpatient settings. Therefore, we believe that all 7 of the measures related to the treatment of pneumonia are likely appropriately reflective of the quality of the care systems established by hospitals for outpatients with a diagnosis of pneumonia.

There are 4 quality measures related to the treatment of patients with heart failure, including assessment of their cardiac function, use of certain medications in their treatment, counseling regarding smoking cessation, and provision of discharge instructions. Patients with heart failure, a common chronic medical condition, are seen frequently in hospital clinics and emergency departments with exacerbations of their symptoms. Once again, their initial treatment is often standardized and provided in the outpatient setting without consideration of their eventual discharge from the outpatient department or inpatient admission, a decision which ultimately depends on clinical considerations, including their response to treatment. Thus, we believe that all 4 of the inpatient quality measures regarding the treatment of patients with heart failure are reasonable surrogates for the quality of hospital systems of care for outpatients with heart failure.

Likewise, under the expanded list of quality measures for the FY 2007 IPPS the surgical infection prevention quality measures indicating the provision of a prophylactic antibiotic within 1 hour prior to surgical incision and prophylactic antibiotics discontinued within 24 hours after surgery end time likely serve as a reasonable representation of the quality of surgical care for hospital outpatients. Many of the same surgical procedures are commonly performed on both hospital outpatients and inpatients, sometimes in the same operating room suites with attendance by the same clinical staff. Hospitals often have standardized protocols for providing antibiotics prior to surgery and postoperatively based on the types of procedures performed, rather than on the inpatient or outpatient status of the patient, and a decision to admit a patient may not even be made until after the completion of a procedure. Thus, we have no reason to believe that the preoperative and postoperative antibiotic experiences of a patient undergoing outpatient surgery would systemically vary from that of a hospital inpatient.

In summary, we believe that quality improvement is usually a function of the entire institution as an integrated system that provides both inpatient and outpatient services to patients with an overlapping range of medical conditions. Quality improvement in a hospital inpatient department is likely to correlate with, and indeed to promote, similar quality improvement in the hospital's outpatient department and other sectors of the institution. Conversely, hospitals that fail to promote quality improvement in key sectors such as inpatient care are also unlikely to improve quality in the hospital outpatient department. We believe that the FY 2007 IPPS quality measures for multiple clinical conditions reflect the quality of hospitals' systems of care that customarily include key outpatient settings such as the emergency department. Therefore, as an interim measure while specific quality measures are being developed and refined for reporting on the quality of care to hospital outpatients, we are proposing that the initial CY 2007 OPPS RHQDAPU incorporate all of the quality measures that are applicable to the IPPS during FY 2007.

We welcome public comments on the applicability to the OPPS of the various FY 2007 IPPS quality measures as proxies for the quality of care in hospital systems that include outpatient departments, with consideration of both the 10 starter set measures and the 11 new measures in the expanded set for FY 2007.

Elsewhere in this proposed rule (section XXIII.), proposed additional quality measures for hospital reporting of quality data for the FY 2008 IPPS are discussed in detail. The proposed areas of expansion for the FY 2008 IPPS include the HCAHPS® survey, which incorporates questions measuring patients' perspectives on their hospital experiences; 3 additional measures related to the processes of surgical care to supplement the 2 initial Surgical Care Improvement Project (SCIP) measures to be implemented in FY 2007; and 3 risk-adjusted assessments of mortality within 30 days of hospital admission for acute myocardial infarction, heart failure, and pneumonia. For the same reasons detailed above for the FY 2007 IPPS SCIP measures, we believe that the additional surgical process of care measures are a reasonable interim proxy for the quality of surgical care for hospital outpatients.

In addition, the questions on the hospital HCAHPS® survey assess aspects of the patient's hospital experience, including communication with doctors and nurses, responsiveness of the staff, pain management, and discharge information. These areas of questioning are all relevant to a hospital's care for its outpatients, who may be treated in the hospital outpatient department for an extended period of time, particularly if they are in observation status or recovering from a significant surgical procedure. As described above, because hospitals generally function as integrated systems, with both inpatients and outpatients with related medical conditions passing through the same departments and interacting with similar staff, we believe that this survey of patients who have

been admitted to the hospital may reasonably reflect hospital outpatients' perspectives on their care experiences as well.

Finally, with respect to the 30-day mortality measures, these measures are linked to the same 3 medical conditions for which quality process measures have already been implemented in the IPPS RHQDAPU program, in order to expand the quality data to more fully reflect the true outcomes of care. These mortality measures are risk-adjusted based on historical medical care use, including inpatient and outpatient hospital care and physician offices visits, and reflect outcomes of care specifically for Medicare patients. Since we are proposing that the full set of FY 2007 IPPS process of care quality measures are acceptable proxies for the quality of care to hospital outpatients as previously discussed, and we believe that some of the value of health care process measures is their relative ease of measurement and their ultimate relationship to health outcomes, we believe that the 30-day mortality measures for inpatients may also reflect the quality of care to hospital outpatients with the same medical conditions. In addition, in view of the common clinical courses of acute myocardial infarction, heart failure, and pneumonia in Medicare beneficiaries, it is highly likely that hospital outpatient services may be provided to previously hospitalized patients within the measures' timeframe of 30 days after hospital discharge, thereby contributing to their care and health outcomes.

Therefore, our intention is to adopt the full set of FY 2008 IPPS quality measures as proposed for the CY 2008 OPPS RHQDAPU program, while we continue to develop a set of specific quality measures for hospital outpatient care.

We welcome public comments on the applicability of the FY 2008 IPPS additional quality measures that are proposed in this rule to the care of hospital outpatients. We also welcome public comments on alternative measures of quality of care, including measures of the cost or efficiency of care, that are suitable for adoption to reduce the incidence of lower-quality and high-cost outpatient hospital care for Medicare beneficiaries. We will formalize our proposal regarding the CY 2008 OPPS RHQDAPU program in the CY 2008 OPPS proposed rule, which may include proposing to adopt none, some, or all of the FY 2008 IPPS RHQDAPU measures, and may also reflect quality measures that are discussed in comments on this proposed rule.

For purposes of computing the update to the conversion factor under the OPPS in CY 2007, therefore, we are proposing to reduce the update to the OPPS conversion factor by 2.0 percentage points for any hospital that is eligible to participate in the IPPS RHQDAPU program, but that has had its IPPS payment update reduced because it failed to comply with that program's requirements. Under this proposal, hospitals that fail to qualify for the full CY 2007 OPPS update would receive payments based on a conversion factor of $60.36, reflecting an update of 1.4 percent, in place of the conversion factor of $61.551 reflecting the full update of 3.4 percent.

Under proposed § 419.43(h)(1), in order to avoid reduction to the CY 2007 OPPS update, hospitals that are eligible to participate in the IPPS RHQDAPU program must meet the requirements for receiving the full IPPS update for FY 2007. Updated procedures and requirements for the IPPS RHQDAPU program are included in the FY 2007 IPPS final rule. In addition to publication in the final rule, all revised procedures will be added to the ''Reporting Hospital Quality Data for Annual Payment Update Reference Checklist'' section of the QualityNet Exchange Web site (*www.qnetexchange.org*). For purposes of determining which hospitals have not qualified to receive the full update under the OPPS for CY 2007, we will follow the determination for FY 2007 full IPPS payment update eligibility under the IPPS RHQDAPU program. These determinations will be released on or about September 1, 2006.

As we noted above, we are undertaking this initiative under the authority granted by section 1833(t)(2)(E) of the Act, which authorizes the Secretary to ''establish, in a budget neutral manner, * * * adjustments as determined to be necessary to ensure equitable payments'' under the OPPS. Proposed § 419.43(h)(3) provides that the reduction to the CY 2007 update that we will implement for hospitals that fail to meet the requirements described above will be implemented in a budget neutral manner. Therefore, if we determine that some hospitals will receive a reduced update for CY 2007 as a result of failure to meet the requirements established under this initial phase of the OPPS RHQDAPU program, we will also make an adjustment to the OPPS conversion factor, so that estimated aggregate payments under the OPPS for CY 2007, taking into account the reduced update for some hospitals, equal the aggregate payments that we estimate would have been made in CY 2007 if all hospitals received the full update to the conversion factor. As we noted above, determinations concerning which hospitals fail to meet the requirements for receiving the full update to the OPPS conversion factor in CY 2007 will be available on or about September 1, 2006. We are therefore unable at this time to determine how many hospitals will receive a reduced update in CY 2007, or to determine the budget neutrality adjustment factor that will be necessary to ensure that estimated aggregate payments under the OPPS for CY 2007 do not change as a result of implementing the proposed OPPS RHQDAPU program. However, very few hospitals have failed to qualify for the full annual updates under the IPPS RHQDAPU program. We therefore anticipate that any further adjustment to the CY 2007 conversion factor to satisfy the budget neutrality requirement under section 1833(t)(2)(E) of the Act will be negligible.

It is not our intention to maintain the specific requirements described above beyond a short initial phase of implementing an OPPS RHQDAPU program. Rather our intention is to develop this program beyond its initial stage in at least two ways. As we have stated previously, we believe that it is appropriate and fair during this initial phase of the OPPS RHQDAPU program, to take quality data reporting under the IPPS RHQDAPU program into consideration for purposes of determining the update for hospitals under the OPPS. However, it will be important for a fully developed OPPS RHQDAPU program to be based on reporting measures that are defined in terms of the quality considerations that are most appropriate and applicable in the hospital outpatient setting. In collaboration with health care stakeholders, we intend to begin work on a set of quality and cost of care measures specific to hospital outpatient departments for implementation in a later phase of the OPPS RHQDAPU program. We intend to implement a hospital outpatient-specific set of such quality and cost of care measures at the earliest possible date. Reporting of a more fully developed, outpatient-specific set of quality and cost of care measures may be effective for purposes of determining the update as early as CY 2009. However, in implementing the system we will allow adequate time for development of the appropriate measures; announcement of the quality and cost of care measures we have selected; consideration of comments from the hospital community, patient

advocates, and other stakeholders; establishment of the requisite mechanisms for reporting the measure; and initiation of actual reporting of the measures by hospitals. As we begin to develop such a set of hospital outpatient-specific quality and cost of care measures, we welcome comments on this issue.

Specifically, we invite comments on the following (and related) questions: Which current quality and cost of care measures, such as IPPS quality measures (especially the measure set as expanded under the DRA), physician practice measures, HCAHPS®/ACAHPS®, etc., are most applicable in the hospital outpatient setting? What would be the characteristics of an ideal measure set of quality and cost of care measures for the outpatient setting? What quality and cost of care measures are currently available for the outpatient setting? What privately-led organizations or alliances are best suited to conduct needed development and consensus endorsement of outpatient quality measures?

As we discussed above, for the initial stage of implementing the OPPS RHQDAPU program in CY 2007, hospitals that are paid under the OPPS but that do not qualify as ''subsection (d)'' hospitals will receive the full update to the OPPS conversion factor. However, we believe that it is essential to expand the requirements of the OPPS RHQDAPU program that we are proposing to all hospital outpatient departments paid under the OPPS. We will therefore also undertake to study, for CYs 2008 and beyond, approaches to adapting and expanding the current quality and cost of care measures under the IPPS RHQDAPU program for use in reporting on the quality of outpatient care in hospitals that are paid under the OPPS but that do not qualify as ''subsection (d)'' hospitals. We will also begin development of mechanisms by which these hospitals can report the requisite quality data in a timely and effective manner. We welcome comments on ways in which we can expand the proposed OPPS RHQDAPU program to all hospital outpatient departments that are paid under the OPPS, and on quality and cost of care measures that are specifically appropriate for reporting by hospital outpatient departments paid under the OPPS but that do not qualify as ''subsection (d)'' hospitals.

Our ultimate goal is implementation of an OPPS RHQDAPU program that extends to all hospital outpatient departments that are paid under the OPPS, that is based on a set of quality and cost of care reporting measures that are specific to the hospital outpatient setting, and that is appropriately aligned with developments in quality reporting and value-based purchasing in other payment systems such as the IPPS. We will take into consideration issues related to the appropriate alignment of quality and cost of care reporting and value-based purchasing under the IPPS and OPPS during the planning process mandated by section 5001(b) of the DRA for implementation of inpatient value-based purchasing by FY 2009. We plan to include all hospital services, whether inpatient or outpatient, in the report on implementation of value-based purchasing. We have often heard from stakeholders that a more comprehensive, systematic approach to quality should be our focus. Quality reporting of inpatient and outpatient services is consistent with such comments, and will provide more comprehensive information about the quality of services provided by hospitals. We specifically request comments on the alignment of scope and other issues that should be considered during this planning process, including quality and cost of care reporting measures, data and program infrastructure, incentives, and public reporting of quality and cost of care measures under value-based purchasing.

Finally, we request comments on the most effective use of our authority under section 1833(t)(2)(E) of the Act, in light of the concerning evidence of rapid and uneven payment growth in the OPPS with limited evidence of patient benefit. In particular, commenters who believe that the proposed quality reporting initiative is not the most effective use of this authority should consider submitting comments on alternative, more effective approaches to using this and related authorities available to CMS under the Act to promote higher quality, more equitable care. We do not believe that the status quo, with rapid and uneven growth in spending and limited evidence of its value, is consistent with a sustainable hospital outpatient payment program and affordable health care for Medicare beneficiaries, and we expect to take further steps to address this important concern. As we have noted elsewhere, continuing rapid growth in Medicare spending that is not addressed by effective payment reforms often results in across-the-board reductions in payment rates. In addition, we seek comment on whether section 1833(t)(2)(F) of the Act also supports the proposed use of quality reporting to determine a hospital's update under the OPPS.

XXI. Promoting Effective Use of Health Information Technology

(If you choose to comment on issues in this section, please include the caption ''Health Information Technology'' at the beginning of your comment.)

We recognize the potential for health information technology (HIT) to facilitate improvements in the quality and efficiency of health care services. One recent RAND study found that broad adoption of electronic health records could save more than $81 billion annually and, at the same time, improve quality of care.[5] The largest potential savings that the study identified was in the hospital setting because of shorter hospital stays promoted by better coordinated care; less nursing time spent on administrative tasks; better use of medications in hospitals; and better utilization of drugs, laboratory services, and radiology services in hospital outpatient settings. The study also identified potential quality gains through enhanced patient safety, decision support tools for evidence-based medicine, and reminder mechanisms for screening and preventive care. Despite such large potential benefits, the study found that only about 20 to 25 percent of hospitals have adopted HIT systems.

It is important to note the caveats to the RAND study. The projected savings are across the health care sector, and any Federal savings would be a reduced percentage. In addition, there are significant assumptions made in the RAND study. National savings are projected in some cases based on one or two small studies. Also, the study assumes patient compliance, in the form of participation in disease management programs and following medical advice. For these reasons, extreme caution should be used in interpreting these results.

In summary, there are mixed signals about the potential of HIT to reduce costs. Some studies have indicated that HIT adoption does not necessarily lead to lower costs and improved quality. In addition, some industry experts have stated that factors such as an aging population, medical advances, and increasing provider expenses would make any projected savings impossible.

[5] RAND News Release: RAND Study Says Computerizing Medical Records Could Save $81 Billion Annually and Improve the Quality of Medical Care, September 14, 2005, available at: *http://rand.org/news/press.05/09.14.html.*

In his 2004 State of the Union Address, President Bush announced a plan to ensure that most Americans have electronic health records within 10 years.[6] One part of this plan involves developing voluntary standards and promoting the adoption of interoperable HIT systems that use these standards. The 2007 Budget states that ''The Administration supports the adoption of health information technology (IT) as a normal cost of doing business to ensure patients receive high quality care.''

Over the past several years, CMS has undertaken several activities to promote the adoption and effective use of HIT in coordination with other Federal agencies and with the Office of the National Coordinator for Health Information Technology. One of those activities is promotion of data standards for clinical information, as well as for claims and administrative data. In addition, through our 8th Scope of Work contract with the QIOs, we are offering assistance to hospitals on how to adopt and redesign care processes to effectively use HIT to improve the quality of care for Medicare beneficiaries, including computerized physician order entry (CPOE) and bar coding systems. Finally, our Premier Hospital Quality Incentive Demonstration provides additional financial payments for hospitals that achieve improvements in quality, which effective HIT systems can facilitate.

We are considering the role of interoperable HIT systems in increasing the quality of hospital services while avoiding unnecessary costs. As noted above, the Administration supports the adoption of HIT as a normal cost of doing business. While payments under the OPPS do not vary depending on the adoption and use of HIT, hospitals that leverage HIT to provide better quality services may more efficiently reap the reward of any resulting cost savings. In addition, the adoption and use of HIT may contribute to improved processes and outcomes of care, including shortened hospital stays and the avoidance of adverse drug reactions. We are seeking comments on our statutory authority to encourage the adoption and use of HIT. We also are seeking comments on the appropriate role of HIT in any value-based purchasing program, beyond the intrinsic incentives of the OPPS, to provide efficient care, encourage the avoidance of unnecessary costs, and increase quality of care. In addition, we are seeking comments on promotion of the use of effective HIT through hospital conditions of participation, perhaps by adding a requirement that hospitals use HIT that is compliant with and certified in its use of the HIT standards adopted by the Secretary. We anticipate that the American Health Information Community will provide advice to the Secretary on these issues.

[6] Transforming Health Care: The President's Health Information Technology Plan, available at: *http://www.whitehouse.gov/infocus/technology/economic_policy200404/chap3.html.*

XXII. Health Care Information Transparency Initiative

(If you choose to comment on issues in this section, please include the caption ''Transparency of Health Care Information'' at the beginning of your comment.)

The United States (U.S.) faces a dilemma in health care. Although the rate of increase in health care spending slowed last year, costs are still growing at an unsustainable rate. The U.S. spends $1.9 trillion on health care, or 16 percent of the gross domestic product (GDP). By 2015, projections are that health care will consume 20 percent of GDP. The Medicare program alone consumes 3.4 percent of the GDP; by 2040, it will consume 8.1 percent of the GDP and by 2070, 14 percent of the GDP.

Part of the reason health care costs are rising so quickly is that most consumers of health care—the patients—are frequently not aware of the actual cost of their care. Health insurance shields them from the full cost of services, and they have only limited information about the quality and costs of their care. Consequently, consumers do not have the incentive or means to carefully shop for providers offering the best value. Thus, providers of care are not subject to the competitive pressures that exist in other markets for offering quality services at the best possible price. Reducing the rate of increase in health care prices and avoiding health services of little value could help to stem the growth in health care spending, and potentially reduce the number of individuals who are unable to afford health insurance. Part of the President's health care agenda is to expand Health Savings Accounts (HSAs), which would provide consumers with greater financial incentives to compare providers in terms of price and quality, and choose those that offer the best value.

In order to exercise those choices, consumers must have accessible and useful information on the price and quality of health care items and services. Typically, health care providers do not publicly quote or publish their prices. Moreover, list prices, or charges, generally differ from the actual prices negotiated and paid by different health plans. Thus, even if consumers were financially motivated to shop for the best price, it would be very difficult at the current time for them to access usable information.

For these reasons, DHHS is launching a major health care information transparency initiative in 2006. This effort builds on steps taken by CMS to make quality and price information available. For example, Medicare has provided unprecedented information about drug prices in the Medicare drug benefit, and is now adding to these efforts in other areas. We recently posted Medicare payment information for common elective procedures and other common admissions for all hospitals by county on our Web site at *http://www.cms.hhs.gov/HealthCareConInit/01_Overview.asp#TopOfPage.* We will post geographically-based Medicare payment information for common elective procedures for ambulatory surgery centers this summer and for common hospital outpatient and physician services this fall.

In addition, a number of tools providing usable health care information are already available to Medicare beneficiaries. Consumers can access ''Compare'' Web sites through *http://www.medicare.gov* where they can evaluate important aspects of their health care options for care at a hospital, nursing home, home health agency, and dialysis facility, as well as compare their costs and coverage when choosing a prescription drug plan.

CMS is developing a transparency initiative with the goals of providing more comprehensive information on quality and costs, including more complete measures of health outcomes, satisfaction, and volume of services that matter to consumers, and more comprehensive measures of costs for entire episodes of care, not just payments for particular services and admissions. We intend for the project to combine public and private health care data to provide cost and quality of care information at the physician and hospital levels. Quality, cost, pricing, and patient information will be reported to consumers and purchasers of health care in a meaningful and transparent way. In addition, we anticipate the project will provide a national template for performance measures and a payment structure that aligns payment and performance.

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

(If you choose to comment on issues in this section, please include the caption ''FY 2008 IPPS RHQDAPU'' at the beginning of your comments.)

A. Background

Section 5001(a) of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171) sets out new requirements for the IPPS Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The IPPS RHQDAPU program was established to implement section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) (Pub. L. 108–173). It builds on our ongoing voluntary Hospital Quality Initiative which is intended to empower consumers with quality of care information to make more informed decisions about their health care while also encouraging hospitals and clinicians to improve the quality of care.

Section 5001(a) of Pub. L. 109–171 revises the mechanism used to update the standardized amount for payment for hospital inpatient operating costs. New sections 1886(b)(3)(B)(viii)(I) and (II) of the Act provide that the payment update for FY 2007 and each subsequent fiscal year will be reduced by 2.0 percentage points for any ''subsection (d) hospital'' that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary. Under sections 1886(b)(3)(B)(viii)(III) and (IV) of the Act, we must expand the ''starter set'' of quality measures that we have used since FY 2005, and to begin to adopt the baseline set of performance measures as set forth in a 2005 report issued by the Institute of Medicine of the National Academy of Sciences (IOM) under section 238(b) of the MMA, effective for payments beginning with FY 2007. The 2005 IOM report's ''baseline'' quality measures include Hospital Quality Alliance (HQA)-approved clinical quality measures, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) patient perspective survey, and three structural measures. The structural measures are: (1) Implementation of computerized provider order entry for prescriptions, (2) staffing of intensive care units with intensivists, and (3) evidence-based hospital referrals. These measures originate from the Leapfrog Group's original ''three leaps,'' and are part of the NQF's 30 safe practices.

In 2002, the Secretary of HHS initiated a partnership with several collaborators intended to promote hospital quality improvement and public reporting of hospital quality information. This collaboration is known as the Hospital Quality Alliance (HQA). The collaborators include the American Hospital Association, the Federation of American Hospitals, the Association of American Medical Colleges, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Quality Forum (NQF), the American Medical Association, the Consumer-Purchaser Disclosure Project, the American Association of Retired Persons, the American Federation of Labor Congress of Industrial Organizations, the Agency for Healthcare Research and Quality, as well as CMS, Quality Improvement Organizations (QIOs), and others.

In the FY 2007 IPPS proposed rule, we proposed to add to our 10-measure ''starter set'' of quality measures, 11 HQA-approved measures for purposes of the FY 2007 update (71 FR 24093).

Under section 1886(b)(3)(B)(viii)(V) of the Act, for payments beginning with FY 2008, we are required to add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, must include measures set forth by one or more national consensus building entities.

Commenters on the FY 2007 IPPS proposed rule requested that we notify the public as far in advance as possible of any proposed expansions of the measure set and program procedures to encourage broad collaboration and to give hospitals time to prepare for any anticipated changes. Other commenters requested that we adopt additional quality measures and that we do as soon as feasible. For example, several commenters urged that we adopt the HCAHPS® patient survey as a part of the IPPS RHQDAPU program, while others suggested that we adopt more of the IOM measures as well as more outcome measures, including mortality measures that were not included in the 2005 IOM report's ''baseline'' quality measures. In response to these comments and as part of our continuing efforts to strengthen the IPPS RHQDAPU program, we are seeking comments on this proposal to expand, for FY 2008, the measurement set beyond those measures we proposed to adopt for purposes of the FY 2007 update. This proposed expanded set would further broaden the scope of the IPPS RHQDAPU program by including the HCAHPS® patients' perspectives of care measures as well as surgical care and mortality outcome measures.

B. Proposed Additional Quality Measures for FY 2008

1. Introduction

For FY 2008, we propose to add the following categories to the measure set:

- *HCAHPS® Survey*

HCAHPS® is also known as Hospital CAHPS or the CAHPS Hospital Survey. The HCAHPS® survey is composed of the following 27 questions:

+ 18 substantive questions that measure critical aspects of the hospital experience (communication with doctors; communication with nurses; responsiveness of hospital staff; cleanliness and quietness of hospital environment; pain management; communication about medicines; and discharge information).
+ 4 questions that direct patients to complete only those survey questions that apply to them.
+ 3 questions to be used to adjust the mix of patients across hospitals.
+ 2 questions that support Congressionally-mandated reports, the ''National Healthcare Disparities Report,'' and the ''National Healthcare Quality Report.''

- *Surgical Care Improvement Project (SCIP)*

+ SCIP–VTE 1: Venous thromboembolism prophylaxis ordered for surgery patient
+ SCIP–VTE 2: VTE prophylaxis within 24 hours pre/post surgery
+ SCIP Infection 2: Prophylactic antibiotic selection for surgical patients

- *Mortality*

+ AMI 30-day mortality—Medicare patients
+ HF 30-day mortality—Medicare patients
+ Pneumonia 30-day mortality—Medicare patients

We discuss these proposed measures in detail below.

2. HCAHPS® Survey and the Hospital Quality Initiative

We have partnered with the Agency for Healthcare Research and Quality (AHRQ), another HHS agency, to develop HCAHPS®. The intent of the HCAHPS® initiative is to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives of hospital care. While many hospitals currently collect information on patients' satisfaction with care, there is currently no national standard for collecting or publicly reporting this information that would enable valid comparisons to be made across hospitals. To make the appropriate comparisons to support consumer choice, we believe it is necessary to

introduce a standard measurement approach. HCAHPS® can be viewed as a core set of questions that can be combined with a broader, customized set of hospital-specific items. HCAHPS® is intended to complement the data hospitals currently collect to support improvements in internal customer services and quality related initiatives within the hospital.

Three broad goals have shaped HCAHPS®. The survey is designed to produce data on the patient's perspective on care that allows objective and meaningful comparisons between hospitals on issues that are important to consumers. In addition, public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care. Also, public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the HCAHPS® initiative has taken substantial steps to assure that the survey will be credible, useful, and practical.

Throughout the HCAHPS® development process, AHRQ and CMS have solicited and received a great deal of public input. AHRQ published a **Federal Register** notice that called for measures in July 2002 (67 FR 48477) and we solicited input on drafts of the HCAHPS® instrument and its implementation strategy (February 2003, June 2003, and December 2003—68 FR 5889, 68 FR 38346, 68 FR 68087). In addition to the public comments received, results from a 3-State Pilot Study were used to reduce the pool of 66 survey questions to 25 questions.

In addition to the development and review processes, we submitted the 25-item version of the HCAHPS® instrument to the NQF. The NQF is a voluntary consensus standard-setting organization established to standardize health care quality measurement and reporting for its review and endorsement through its consensus development process. NQF endorsement represents the consensus of numerous health care providers, consumer groups, professional associations, purchasers, Federal agencies, and research and quality organizations. Following a thorough, multi-stage review process, HCAHPS® was endorsed by the NQF board in May 2005. In the process, NQF recommended a few modifications to the instrument. As a result of the recommendations of the NQF Consensus Development Process, questions regarding courtesy and respect were added to the survey. The NQF review committee believes that these questions are important to all patients, and may be particularly meaningful to patients who are members of racial and ethnic minority groups. Upon the recommendation of the NQF, we further examined the costs and benefits of the 27-item HCAHPS® survey. This cost-benefit analysis of HCAHPS® was conducted by Abt Associates, Inc. The report of this analysis can be found at *http://www.cms.hhs.gov/HospitalQualityInits/downloads/HCAHPSCostsBenefits200512.pdf.*

We published a **Federal Register** notice soliciting comments on the draft 27-item HCAHPS® Survey in November 2005 (70 FR 67476). The HCAHPSreg; survey received approval by the Office of Management and Budget (OMB) on December 22, 2005.

Shortly thereafter, we began final preparations for the voluntary national implementation (as a part of the Hospital Quality Initiative) with the support of the HQA. The HQA is a private/public partnership that includes the American Hospital Association, the Federation of American Hospitals, the Association of American Medical Colleges, JCHAO, NQF, American Association of Retired Persons (AARP), CMS, AHRQ, and other stakeholders who share a common interest in reporting on hospital quality. The HQA has been proactive in making performance data on hospitals accessible to the public, thereby improving patient care.

We also offered training sessions for hospitals self-administering the survey and survey vendors acting on behalf of hospitals in February and April 2006. Since HCAHPS® was a new initiative, we decided that it was critical to hospitals, survey vendors, and CMS to acquire first-hand experience with data collection, including sampling and data submission to the QualityNet Exchange, prior to collecting data for public reporting. For hospitals participating in the national implementation of HCAHPS® on October 1, 2006, we required participation in a short dry run period of at least one month. A hospital could choose to sample and survey discharges in April, May, and/or June 2006. Data from this ''dry run'' are not publicly reported.

National implementation begins October 2006 for this first set of hospitals and survey vendors that will be participating in the HCAHPS® voluntary initiative The initial public reporting period will cover nine months of patient discharges (October 2006 through June 2007). In late 2007, hospital results will be publicly reported on the CMS Hospital Compare Web site (*http://www.hospitalcompare.hhs.gov*). After the initial implementation, the Web site will contain 12 months of HCAHPS® data and will be updated quarterly.

The HCAHPS® survey is currently available in English and Spanish. During the HCAHPS® dry run and initial national implementation (discussed more fully below), we will be soliciting comments from participating hospitals and survey vendors regarding additional languages for HCAHPS®. This information can be submitted to our HCAHPS® mailbox, *CMSHOSPITALCAHPS@cms.hhs.gov*. From the information we receive, we will establish priorities for HCAHPS translation into additional languages.

In order for the remaining hospitals to participate in HCAHPS®, future training sessions for hospital personnel and survey vendors will take place in early 2007. Hospitals may choose to self-administer HCAHPS®, or may choose to hire a vendor who has completed the training. A brief dry run of March 2007 discharges will allow newly participating hospitals and vendors to get ''first-hand'' experience with all phases of the data collection and submission process. Details about the HCAHPS® requirements, and the additional requirements proposed for HCAHPS® under the IPPS RHQDAPU program, are included in section XXIII.C. and XXIII.D. of this preamble.

3. Surgical Care Improvement Project (SCIP) Quality Measures

The Surgical Care Improvement Project (SCIP) is a national quality partnership of organizations committed to improving the safety of surgical care through the reduction of post-operative complications. The primary goal of the partnership is to save lives by reducing the incidence of surgical complications by 25 percent by the year 2010. Partners in SCIP believe that a meaningful reduction in complications requires a systems approach to our challenges, which means that surgeons, anesthesiologists, primary care physicians and internal medicine specialists, perioperative nurses, pharmacists, infection control professionals, and hospital executives must work together to make surgical care improvement a priority. SCIP partners coordinate their efforts through a steering committee that includes representatives of the American Hospital Association, the American College of Surgeons, the American Society of Anesthesiologists, the Association of Perioperative Registered Nurses, the JCAHO, the Institute of Healthcare Improvement, the

Department of Veterans Affair (VA), the Agency for Healthcare Research and Quality (AHRQ), CMS and the Centers for Disease Control and Prevention (CDC).

SCIP is a comprehensive program, integrated into the quality improvement agenda of the CMS, JCAHO, the CDC, the American College of Surgeons, the Veterans Health Administration, as well as the other organizations that comprise the SCIP Steering Committee. There are a number of activities underway from these and other partnering organizations.

4. Mortality Outcome Measures

CMS recognizes that the current set of hospital performance measures should be expanded to more fully reflect outcomes of care. The 30-day mortality measures for patients with acute myocardial infarction (AMI), heart failure (HF) and pneumonia are three separate claims-based, risk-adjusted assessments of mortality within 30 days of admission for each of the three conditions. The measures reflect outcomes of care for Medicare patients only, and rely on Medicare patients' historical medical care use, including inpatient and physician office visits and outpatient care 1 year before their hospitalizations, for the risk adjustment calculation.

The 30-day mortality rate measures for AMI and HF were endorsed by the NQF in 2005 (see *http://www.qualityforum.org/news/tb3Hospspecsforweb02-10-06.pdf*). We anticipate that the 30-day mortality rate measure for pneumonia will also be endorsed by the NQF since it reflects the same underlying methodology as the other 30-day mortality measures.

In contrast to the HCAHPS® and SCIP quality measures added to the measure set for FY 2008, no additional data collection from hospitals will be required to calculate the 30-day mortality measures. All three measures can be calculated based on Medicare inpatient and outpatient claims data that are already reported to the Medicare program for payment purposes. We anticipate that we will conduct a national dry run for the AMI and HF measures in late 2006 to test implementation and educate hospitals on the methodology. During this dry run, hospitals will be given the opportunity to examine their rates and other data associated with the measures, and to provide feedback to CMS on questions related to the calculation of the rates. The rates that will be developed for the dry run will be used for quality improvement purposes and will not be publicly reported to the Hospital Compare. More information about the dry run will be provided to hospitals through QualityNet Exchange Web site (*http://www.qnetexchange.org*).

We expect to calculate and publicly report 30-day mortality rates for the AMI and HF conditions in the June 2007 update of the Hospital Compare Web site. Rates for the 30-day pneumonia mortality measure will be posted as soon as possible after we receive NQF endorsement. As is currently the case for the other measures, hospitals will be provided a 30-day period in which they will be permitted to preview their rates before publication. As is currently the case for the ''starter set'' measures, hospitals that have pledged to submit data for full annual payment update for FY 2008 will not be permitted to suppress or withhold publication of the rates on the Hospital Compare Web site, except under highly limited circumstances.

C. General Procedures and Participation Requirements for the FY 2008 IPPS RHQDAPU Program

All revised procedures for FY 2008 also will be added to the ''Reporting Hospital Quality Data for Annual Payment Update Reference Checklist'' section of the QualityNet Exchange Web site. This checklist also links to all of the forms to be completed by hospitals participating in the program.

To participate in the RHQDAPU program, we are proposing that hospitals must follow these steps:

- Complete all registration steps; this information can be found on ''Reporting Hospital Quality Data for Annual Payment Update Reference Checklist'' located on the QualityNet Exchange Web site.
- Continue to collect data for all clinical quality measures that are currently part of the RHQDAPU program, and submit the data to the QIO Clinical Warehouse either using the CMS Abstraction & Reporting Tool (CART), the JCAHO ORYX® Core Measures Performance Measurement System, or another third-party vendor tool that has met specification requirements for data transmission to QualityNet Exchange. The submission must be done through QualityNet Exchange. Because the information in the QIO Clinical Warehouse is considered QIO information, it is subject to the stringent QIO confidentiality regulations in 42 CFR Part 480.

In addition, for purposes of the annual payment update, we will continue to require hospitals to pass our validation requirements. We originally set forth these requirements in the FY 2006 IPPS final rule (70 FR 47421), and we will continue to require that hospitals achieve an 80-percent reliability. We will also continue to post information related to validation requirements on the QualityNet Exchange Web site.

In addition to these general procedures, the specific procedures below apply to these proposed additional measures.

D. HCAHPS® Procedures and Participation Requirements for the FY 2008 IPPS RHQDAPU Program

1. Introduction

Under sections 1886(b)(3)(B)(viii)(III) and (IV) of the Act, CMS must begin to adopt the baseline set of performance measurements as set forth in a 2005 report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of Pub. L. 108–173, effective for payments beginning with FY 2007. The 2005 IOM report recommends that we expand the ''starter'' measures by including the HCAHPS® patient perspective survey. We began to adopt the IOM measures in the FY 2007 IPPS final rule, in which we adopted 11 additional HQA-approved quality measures. In this proposed rule, we are proposing to expand the set of IOM measures hospitals will be required to report to receive the full IPPS market basket update for FY 2008. In addition, section 1886(b)(3)(B)(viii)(V) of the Act states that effective for payments beginning with FY 2008, we must add ''other measures that reflect consensus among affected parties and, to the extent feasible and practicable,'' include ''measures set forth by one or more national consensus building entities.'' Accordingly, we are proposing to add additional SCIP quality and measures and three 30-day mortality measures.

2. HCAHPS® Hospital Pledge and Beginning Date for Data Collection

Under the FY 2008 RHQDAPU program, we are proposing that hospitals will need to submit HCAHPS® data to the QIO Clinical Warehouse beginning with discharges that occur in the third calendar quarter of 2007 (July through September discharges). In order to meet HCAHPS® requirements for the RHQDAPU program, we are proposing that all hospitals, including hospitals new to HCAHPS® and hospitals that have been collecting data since October 1, 2006, must submit a formal pledge to CMS by July 1, 2007 stating that they will collect and submit HCAHPS® data to the QIO Clinical Warehouse starting

with July 2007 discharges. We are proposing that to meet HCAHPS® requirements for the RHQDAPU program for FY 2008, all hospitals must submit this pledge to CMS.

3. HCAHPS® Dry Run

We are proposing to require that hospitals that have not had experience collecting and submitting HCAHPS® data to the QIO Clinical Warehouse as a result of participating in the 2006 voluntary initiative must participate in a dry run of the survey in March 2007. We are proposing to require the submission of March 2007 dry run data to the QIO Clinical Warehouse by July 13, 2007 from those hospitals not yet collecting and submitting HCAHPS® data.

4. HCAHPS® Data Collection Requirements

To collect HCAHPS® data, we are proposing that a hospital can either contract with an approved HCAHPS® survey vendor that will conduct the survey and submit data on the hospital's behalf to the QIO Clinical Warehouse, or a hospital can self-administer the survey without using a survey vendor provided that the hospital meets Minimum Survey Requirements as specified at (*http://www.HCAHPSonline.org/programapplication.asp*). A current list of approved HCAHPS® survey vendors can be found at *http://www.HCAHPSonline.org/app_vendor.asp.*

5. HCAHPS® Registration Requirements

• We are proposing that HCAHPS® registration requirements for the RHQDAPU program will include:

+ The hospital must be a registered user of QualityNet Exchange. Hospitals that are self-administering HCAHPS® or survey vendors hired by the hospitals must collect and submit HCAHPS® survey person-level data electronically to the QIO Clinical Warehouse via QualityNet Exchange, using prescribed file specifications that can be found at *http://www.HCAHPSonline.org/techspecs.asp.*

6. Additional Steps for HCAHPS® Participation

In order to participate in HCAHPS®, we are proposing that hospitals that self-administer the survey and survey vendors that collect and submit data on behalf of client hospitals must follow these steps:

• *Attend Hospital/Survey Vendor Training.* Hospitals and survey vendors that intend to actually administer the survey must attend HCAHPS® training. Hospitals contracting with a survey vendor or another hospital to administer the survey on behalf of the hospital do not need to attend training. The next training session will be offered via Webinar in late January 2007. Please see *http://www.HCAHPSonline.org* for updated information on training opportunities and registration. At a minimum, the hospital's or survey vendor's project manager must attend the HCAHPS® training for administering the survey. Hospitals and survey vendors that attended training in February or April 2006 and are participating in the voluntary HCAHPS data submission beginning October 2006 do not need to participate in the January 2007 training sessions. In addition, we may hold short refresher training sessions for all hospitals self-administering the survey and survey vendors in the spring of 2007.

• *Review and follow the HCAHPS® Quality Assurance Guidelines and Updates.* HCAHPS Quality Assurance Guidelines have been developed to standardize the survey data collection process and to ensure comparability of data reported through HCAHPS®. They are located on *http://www.hcahpsonline.org* and will also be presented at the HCAHPS® hospital/survey vendor training.

The HCAHPS® Quality Assurance Guidelines (the Guidelines) provide detailed information regarding: technical support; sampling protocols; the four allowed modes of survey administration; data specifications and coding; data preparation and submission; data reporting and the exceptions process. The Guidelines describe technical support that is available to hospitals and survey vendors administering HCAHPS® by using a toll-free number or by e-mail. It provides details regarding the protocol for sampling involving drawing a simple random sample each month from the sampling frame of eligible discharges. Sampling can be done at one time after the end of the month, or continuously throughout the month, as long as a simple random sample is generated for the month. The Guidelines include very specific information about the four allowed modes of survey administration: mail only, telephone only, a mixed methodology of mail with telephone follow up, and active interactive voice response (IVR). All modes of administration require following a standardized protocol. The Guidelines describe a standardized approach for the coding of all data from assigning the unique tracking number, the decision rules for capturing data, the file specifications, the file layout, the procedure for assigning disposition codes, the definition of a completed survey, and the procedure for calculating the total survey response rate. Data preparation and submission guidelines cover registration for data submission via the QualityNet Exchange, creation of data files, instructions for data submission via the QualityNet Exchange, and confirmation of accuracy of data. Data reporting covers internal and external reports; among them are the hospital preview reports and the public reports on CMS Hospital Compare. The Quality Assurance Guidelines describe the exceptions process to review requests for methodologies that vary from the standard HCAHPS® protocols and the appeals process if an exception is denied. For the initial implementation phase of the HCAHPS® survey, we are proposing that no exceptions to the four approved modes of survey administration will be allowed.

In addition, hospitals/survey vendors must follow any updates that are posted on *http://www.HCAHPSonline.org.*

• *Develop Hospital/Survey Vendor HCAHPS® Quality Assurance Plan.* Hospitals self-administering the survey and survey vendors must develop a Quality Assurance Plan for survey administration in accordance with the Quality Assurance Guidelines presented at the HCAHPS® hospital/survey vendor training and posted on *http://www.HCAHPS® online.org/programapplication.asp.* The HCAHPS® Quality Assurance Plan should include the following:

+ Organizational chart

+ Work plan for survey implementation

+ Description of survey procedures and quality controls

+ Plans for quality assurance oversight of on-site work and of all subcontractors' work (including survey vendor, if used)

+ Confidentiality/Privacy and Security procedures in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

The hospital or survey vendor must make the HCAHPS® Quality Assurance Plan available to the HCAHPS® project team upon request. The project team includes CMS, the Health Services Advisory Group (HSAG) that is helping CMS implement HCAHPS, and HSAG's subcontractors for this project.

• *Attest to the Accuracy of the Organization's Data Collection.* Hospitals self-administering the survey and survey vendors must review and agree that the HCAHPS survey was administered in accordance with the HCAHPS® Quality Assurance Guidelines.

• *Participate in HCAHPS® oversight activities.* Hospitals and survey vendors must participate in a quality oversight process conducted by the HCAHPS® project team. Prior to July 2007, the purpose of the oversight activities will be to provide feedback to hospitals and survey vendors on data collection procedures. Starting in July 2007, CMS may ask hospitals/survey vendors to correct any problems that are found and provide follow-up documentation of corrections for review within a defined time period. If we find that the hospital has not made these corrections, CMS may determine that the hospital is not submitting appropriate HCAHPS® data for the RHQDAPU program.

As part of these activities, HCAHPS® project staff will review and discuss with survey vendors and hospitals self-administering the survey their specific Quality Assurance Plans; survey management procedures; sampling and data collection protocols; and data preparation and submission. This review may take place in-person or through other means of communication.

7. HCAHPS® Survey Completion Requirements

We are proposing that hospitals must submit complete HCAHPS® data in accordance with the HCAHPS® Quality Assurance Guidelines located at *http://www.HCAHPSonline.org* and made available at the hospital/survey vendor training. These requirements specify that hospitals are required to survey a random sample of eligible discharges on a monthly basis. Hospitals should target to collect at least 300 completed surveys over the public reporting period. For the initial HCAHPS® national implementation, the public reporting period is 9 months, from October 2006 through June 2007. After this initial implementation, the public reporting period will be 12 months and hospitals should be targeting to collect at least 300 completed HCAHPS® surveys over a 12 month period. The initial public reporting period is 9 months, because of the broad interest of making HCAHPS results publicly available as quickly as possible. Smaller hospitals that cannot collect 300 completed HCAHPS® surveys during a public reporting period will only be required to collect as many completed surveys as possible. A small hospital is defined for the purposes of HCAHPS® as any hospital that cannot achieve 300 completed HCAHPS® surveys during a public reporting period, because of its dearth of eligible hospital discharges during that period. For those hospitals that cannot collect 300 completed HCAHPS® surveys, we plan to note this on *http://www.hospitalcompare.hhs.gov* that the results for those hospitals are based on less than 100 completed HCAHPS® surveys or between 100 and 299 completed HCAHPS® surveys.

8. HCAHPS® Public Reporting

We propose to display HCAHPS® data on our Web site for public viewing in accordance with section 1886(b)(3)(B)(viii)(VII) of the Act, which states that the Secretary must report quality measures that relate to patients' perspectives on care on our Web site. Before we display this information, hospitals will be permitted to review their data to be made public as we have recorded it.

As we discussed above, there are 27 questions included in the HCAHPS® survey. The survey is comprised of substantive questions that directly pertain to seven domains of primary importance to the target audience: Doctor communication, nurse communication; cleanliness and quiet of the hospital environment; responsiveness of hospital staff; pain management; communication about medicines; and discharge information. It also includes two overall questions that measure the patient's overall satisfaction with the hospital and willingness to recommend the hospital.

Each of the seven domains is constructed from two or three questions from the survey and is reported as a composite score. For public reporting purposes, the seven composite scores and two overall ratings will be displayed. There will be both national and state comparisons for each of the nine reported results. We are currently conducting testing with consumers to ensure that the HCAHPS® displays on *http://www.hospitalcompare.hhs.gov* are consumer friendly. Generally, for CAHPS ® measures in other settings we display bar graphs with the top response categories, such as the percent of people surveyed that gave the hospital a ''10'' for a 0 to 10 rating, or the percent that said their doctors ''always'' communicate well. Users of the site can ''drill down'' to get more detailed information regarding the distribution for the response categories underlying the survey questions.

9. Reporting HCAHPS® Results for Multi-Campus Hospitals

Currently, hospitals that share Medicare provider numbers combine their clinical data across campuses for submission and publication of their data. Our current plan for HCAHPS® is for these data to be combined across campuses. However, we are considering ways in which data could potentially be displayed by campus rather than by hospital system in the future. As a starting point, we are trying to determine a way to identify those hospitals that share Medicare provider numbers, which will allow CMS to denote that the measures are made up of multiple campuses on *http://www.hospitalcompare.hhs.gov.* In the future, if feasible, we would like to move towards obtaining and reporting information at the campus level. We encourage comments regarding this issue.

E. SCIP & Mortality Measure Requirements for the FY 2008 RHQDAPU Program

• We are proposing that hospitals be required to complete and return a written form on which they agree to participate in the RHQDAPU program for FY 2008.

• For the SCIP measures, we are proposing to require hospitals to submit data starting with discharges that occur in CY 2007. Hospitals will be required to submit data on these measures to the QIO Clinical Warehouse beginning with discharges that occur in the first calendar year quarter of 2007 (January through March discharges). We are proposing that the deadline for hospitals to submit their data for first calendar quarter of 2007 will be August 15, 2007.

• For the Mortality measures, we are proposing to use claims data that is already being collected for index hospitalizations to calculate the mortality rates, therefore, no additional data will need to be submitted by hospitals for these measures. Index hospitalization is the initial hospitalization for an episode of care. Claims data submitted to CMS for index hospitalizations occurring from July 2005 through June 2006 (3rd quarter CY 2005 through 2nd quarter CY 2006) will be used to calculate the mortality rates that will be used for FY 2008 annual payment determination. These rates will be posted on Hospital Compare in June 2007.

• We are proposing to display on our Web site data collected on the SCIP and Mortality measures for public viewing in accordance with section 1886(b)(3)(B)(viii)(VII) of the Act. Before we display this information, hospitals will be permitted to review their data that are to be made public as we have recorded it.

F. Conclusion

We believe that our proposal to include HCAHPS®, SCIP and Mortality measures as part of the FY 2008 IPPS RHQDAPU program's reporting requirements meets the requirements of

section 1886(b)(3)(B)(viii)(III) of the Act. This provision states that we must expand for FY 2007 and each subsequent fiscal year, consistent with sections 1886(b)(3)(B)(viii)(IV) through 1886(b)(3)(viii)(VII) of the Act, the set of measures that the Secretary determines to be ''appropriate'' for the measurement of care furnished by hospitals in inpatient settings beyond the original 10-measure starter set of quality measures that applied in FY 2005 and FY 2006.

Section 1886(b)(3)(B)(viii)(IV) of the Act requires us to begin to adopt the baseline set of performance measures set forth in the 2005 IOM report effective for payment beginning with FY 2007. We began to adopt these measures for FY 2007 and are now proposing to adopt additional measures, including several measures that are from this report. HCAHPS® and the SCIP Infection 2 measures are measures set forth in the 2005 IOM report. Thus, we believe our proposal to expand the measure set to include HCAHPS® and SCIP Infection 2 measures for the FY 2008 IPPS RHQDAPU program meets this requirement of the Act.

Section 1886(b)(3)(B)(viii)(V) of the Act states that effective for payments beginning with fiscal year 2008, we must add ''other measures that reflect consensus among affected parties and, to the extent feasible and practicable,'' include ''measures set forth by one or more national consensus building entities.'' In addition to proposing to add additional measures from the baseline measures found in the 2005 IOM report, we are proposing to add additional SCIP quality measures and three 30-day mortality measures. In selecting these measures to adopt consistent with this section for the FY 2008 payment update and thereafter, CMS is proposing to add standardized quality measures that have been adopted or endorsed by a national consensus building entity that utilizes a national consensus building process that endorses measures based on (1) its consideration of issues such as the validity, reliability, impact and feasibility of the measures, and (2) input from a wide variety of stakeholders including, but not limited to, health care consumers and patients, clinicians and providers, purchasers, and researchers.

We believe that adopting measures that have been endorsed as a result of this process achieves the type of consensus that Congress envisioned in enacting section 5001(a) of Pub. L. 109–171. The NQF is one consensus building entity that administers this process and takes these factors into account when endorsing measures. NQF is a voluntary consensus standard-setting organization established to standardize health care quality measurement and reporting, for its review and endorsement through its consensus development process. NQF endorsement, which occurs following a thorough, multi-stage review process, represents the consensus of numerous health care providers, consumer groups, professional associations, purchasers, Federal agencies, and research and quality organizations. We recognize that the 30-day Pneumonia mortality is not currently NQF-endorsed. We anticipate, however, that the NQF will endorse this measure soon. We do not plan to adopt the 30-day Pneumonia mortality measure unless it is endorsed by the NQF.

The HQA is another such consensus building entity. The HQA is a public-private collaboration of numerous stakeholder groups. One goal of HQA is to identify a robust set of standardized and easy-to-understand hospital quality measures that would be used by all stakeholders in the health care system in order to improve quality of care and the ability of consumers to make informed health care choices. We also note that HQA currently relies on the NQF process as part of its process.

CMS anticipates that other consensus building entities that take into account the issues of validity, reliability, impact and feasibility of the measures and involves a wide array of stakeholders may develop.

XXIV. Files Available to the Public Via the Internet

Addenda A and B to this proposed rule provide various data pertaining to the proposed CY 2007 payments for services under the OPPS. Addenda AA, BB, and CC to this proposed rule include various data pertaining the proposed ASC list of covered procedures and payment rates for procedures furnished in ASCs in CYs 2007 and 2008, respectively.

To conserve resources and to make Addendum B more relevant to the OPPS, we are including in Addendum B of this proposed rule HCPCS codes (including CPT codes) for services that are assigned a payable status indicator under the OPPS and HCPCS codes for which we are proposing a change in status indicator and/or APC assignment for CY 2007. A list of all active HCPCS codes, regardless of their assigned payable status, is available to the public on the CMS Web site at: *http://www.cms.hhs.gov/providers/hopps.*

For the convenience of the public, we are also including on this same CMS Web site a table that displays the HCPCS data in Addendum B sorted by APC assignment, identified as Addendum C. In addition, we are including on the CMS Web site, in a format that can be easily downloaded and manipulated, Addendum A. Similarly, we are including Addenda AA, BB, and CC on the CMS Web site at: *http://www.cms.hhs.gov/center/asc.asp.*

We are not including as addenda in this proposed rule, reprints of wage index related tables from the FY 2007 IPPS proposed rule (71 FR 24235 through 24272) as they would be used for the OPPS for CY 2007. Rather, we are providing a link on the CMS Web site at: *http://www.cms.hhs.gov/providers/hopps* to all of the proposed FY 2007 IPPS wage index related tables. For additional assistance, contact Anita Heygster, (410) 786–4486.

XXV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The following information collection requirements included in this proposed rule and their associated burdens are subject to the PRA.

We are soliciting public comment on each of the issues for the following section of this document that contain information collection requirements and are not currently approved by the OMB.

Proposed Additional Quality Measures for FY 2008: Surgical Care Improvement Project (SCIP)

Section 5001(a) of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171) sets out new requirements for the IPPS Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. Under section 1886(b)(3)(B)(viii)(V) of the Act, for payments beginning with FY 2008, we

are required to add other measures that reflect consensus among affected parties and, to the extent feasible and practicable, must include measures set forth by one or more national consensus building entities. In this proposed rule, we are setting out the additional measures that we propose to require for FY 2008.

The burden associated with this section is the time and effort associated with collecting, copying and submitting the data. As part of the *Surgical Care Improvement Project (SCIP)*, we estimate that there will be approximately 3,700 respondents per year. All of these hospitals must submit SCIP Infection 1 and 3 to receive the annual payment update covering FY 2007. Additional surgical procedures covering approximately 6,000,000 discharges annually will be sampled at a 10 percent rate per hospital, so an additional 600,000 discharges will be abstracted and submitted by hospitals for the additional SCIP measures (SCIP Infection 2 and VTE 1, 2). The 10 percent sampling rate is a minimum threshold specified in the most current version of the joint CMS/JCAHO Hospital Quality Measures Specifications Manual. We estimate that it will take 450,000 hours (3/4 hour per sampled discharge) to abstract and submit data for these additional sampled discharges.

In addition, hospitals must abstract and submit additional information needed for the additional SCIP measures covering the surgical procedures already covered in SCIP Infection 1 and 3. We estimate that about 275,000 discharges will be sampled and abstracted covering these surgical procedures. We estimate that it will take an additional 137,500 hours (½ hour per sampled discharge) for hospitals to abstract and submit this additional information. Both estimates include overhead.

In total, we estimate that an additional 587,500 hours will be used by hospitals to abstract and submit the additional SCIP measures. This estimate includes overhead.

Further, we note that there is no additional burden associated with the incorporation of mortality outcome measures, as this information is currently collected with claims data.

We have submitted a copy of this proposed rule to the OMB for its review of the aforementioned information collection requirements.

This proposed rule also includes associated information collections for which CMS has obtained the OMB's approval. The following is a discussion of these currently OMB approved collections.

As discussed in section XXIII of this preamble, the IPPS RHQDAPU program expands upon the Hospital Quality Initiative which is intended to empower consumers with quality of care information to make more informed decisions about their health care while also encouraging hospitals and clinicians to improve the quality of care. The information collection associated with the IPPS RHQDAPU is the Hospital Quality Alliance (formerly known as the National Voluntary Hospital Reporting Initiative)—Hospital Quality Measures. The OMB approved this information collection under OMB control number 0938–0918, with an expiration date of December 31, 2008. As a result of the increase from 10 to 21 quality measures, CMS created a revised information collection request to include the new quality measures. CMS announced the revised information collection in a 60-day **Federal Register** notice that published on June 9, 2006 (71 FR 33458). CMS will publish a 30-day **Federal Register** notice prior to the submission of the revised information collection being proposed in this rule to OMB.

Further, as discussed in section XXIII. of this preamble, for FY 2008, we are proposing to expand the IPPS RHQDAPU program to include the HCAHPS® Survey, also known as the Hospital CAHPS or the CAHPS Hospital Survey. The HCAHPS® Survey is composed of 27 questions: 18 substantive questions that encompass critical aspects of the hospital experience (communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness and quietness of hospital environment, pain management, communication about medicines, and discharge information); four questions to skip patients to appropriate questions; three questions to adjust for the mix of patients across hospitals; and two questions to support congressionally-mandated reports. As explained in section XXIII. of this preamble, CMS published a **Federal Register** notice soliciting comments on the draft 27-item HCAHPS® Survey in November 2005 (70 FR 67476). The OMB approved the HCAHPS® Survey under OMB control number 0938–0981, with an expiration date of December 31, 2007.

Proposed Revised § 416.190(c)—Request for Review of Payment Amount

The collection of information requirements at 5 CFR 1320 are applicable to requirements affecting 10 or more entities. Proposed revised § 416.190(c) would require that a request for review of the ASC payment amount for insertion of an IOL must include all the information that CMS specifies on its Web site.

While this section of the proposed rule contains information collection requirements, we estimate that less than 10 ASCs will be affected; therefore, we believe these collection requirements are exempt from OMB for review and approval, as specified at 5 CFR 1320.3(c)(4). Consequently, this section of the proposed rule need not be reviewed by the OMB under the authority of the PRA.

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development Group, Attn: Melissa Musotto, CMS–1506–P, Room C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Carolyn Lovett, CMS Desk Officer, (CMS–1506–P), *carolyn_lovett@omb.eop.gov.* Fax (202) 395–6974.

XXVI. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document(s), we will respond to those comments in the preamble to that document(s).

XXVII. Regulatory Impact Analysis

(If you choose to comment on issues in this section, please include the caption ''Impact'' at the beginning of your comment.)

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), and Executive Order 13132.

1. Executive Order 12866

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibility of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year).

We estimate that the effects of the OPPS provisions that would be implemented by this proposed rule would result in expenditures exceeding $100 million in any 1 year. We estimate that adding 14 procedures to the ASC list and implementing section 5103 of Pub. L. 109–171) in CY 2007 would result in savings to the Medicare program of approximately $150 million. We further estimate that the revised ASC payment system and expanded list of payable ASC services which we are proposing to implement in CY 2008 would have no effect on Medicare expenditures compared to CY 2007. A more detailed discussion of the effects of the proposed changes to the ASC list of procedures for CY 2007 and the effects of proposed revisions to the ASC payment system in CY 2008 is provided in sections XXVII. C. and D. below.

In addition, we estimate that the changes that we are proposing in section XIX. of this preamble to implement Medicare contracting reform mandated by section 911 of Pub. L. 108–173 have no economic effect on current Medicare payments in CY 2007. This aspect of our proposal would amend our current Medicare contractor regulations to conform them to the statutory changes mandated by Pub. L. 108–173 and in and of itself does not affect in any way Medicare's coverage or payment policies for hospital outpatient services or any other covered Medicare services. Accordingly, we believe that this provision has no immediate economic effect on Medicare payments in CY 2007.

Further, we estimate that the changes that we are proposing in section XXIII. of this preamble to implement an expanded set of quality measures for the IPPS Reporting Hospital Quality Data for the Annual Payment Update (RHQDAPU) program in accordance with sections 1886(b)(3)(B)(viii)(III) and (IV) of the Act will not have a significant economic effect on Medicare payments to hospitals in CY 2007. A more detailed discussion of the effects of this proposal are included in section XXIII. of this preamble and section XXVII.F. below.

However, we estimate the total increase (from changes in this proposed rule as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2007 compared to CY 2006 to be approximately $2.98 billion. Therefore, this proposed rule is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to determine whether a rule would have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year (65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals and 73 percent of ambulatory surgery centers would be considered small entities according to the Small Business Administration (SBA) size standards. We do not have data available to calculate the percentages of entities in the pharmaceutical preparation manufacturing, biological products, or medical instrument industries that would be considered to be small entities according to the SBA size standards. For the pharmaceutical preparation manufacturing industry (NAICS 325412), the size standard is 750 or fewer employees and $67.6 billion in annual sales (1997 business census). For biological products (except diagnostic) (NAICS 325414), with $5.7 billion in annual sales, and medical instruments (NAICS 339112), with $18.5 billion in annual sales, the standard is 50 or fewer employees (see the standards Web site at: *http://www.sba.gov/regulations/siccodes/*). Individuals and States are not included in the definition of a small entity.

Not for profit organizations are also considered to be small entities under the RFA. There are 2,163 voluntary hospitals that we consider to be not for profit organizations to which this proposed rule applies.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 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 previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) (or New England County Metropolitan Area (NECMA)). However, under the new labor market definitions that we adopted in the November 15, 2004 final rule with comment period, for CY 2005 (consistent with the FY 2005 IPPS final rule), we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the OPPS, we classify these hospitals as urban hospitals. We believe that the changes to the OPPS in this proposed rule would affect both a substantial number of rural hospitals as well as other classes of hospitals and that the effects on some may be significant although the proposed changes to the ASC payment system for CY 2007 and CY 2008 would have no effect on small rural hospitals. Therefore, we conclude that this proposed rule would have a significant impact on a substantial number of small entities.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. The maximum nationwide cost to hospitals will be $16.9 million for HCAHPS® (Abt Report), $58.7 million in noncaptial costs for SCIP, and no cost for mortality measure. This proposed rule will not mandate any requirements for State, local, or tribal government, nor will it affect private sector costs.

5. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it publishes any rule (proposed or final) that imposes substantial direct costs on State and local governments, preempts State law,

or otherwise has Federalism implications.

We have examined this proposed rule in accordance with Executive Order 13132, Federalism, and have determined that it would not have an impact on the rights, roles, and responsibilities of State, local or tribal governments. As reflected in Table 49 we estimate that OPPS payments to governmental hospitals (including State, local, and tribal governmental hospitals) would increase by 3.0 percent under this proposed rule. The proposals related to payments to ASCs in CYs 2007 and 2008 would not affect payments to government hospitals. In addition, the proposals related to MACs and HCAHPS would not affect payments to government hospitals.

B. Effects of Proposed OPPS Changes in This Proposed Rule

(If you choose to comment on issues in this section, please include the caption ''OPPS Impact'' at the beginning of your comment.)

We are proposing several changes to the OPPS that are required by the statute. We are required under section 1833(t)(3)(C)(ii) of the Act to update annually the conversion factor used to determine the APC payment rates. We are also required under section 1833(t)(9)(A) of the Act to revise, not less often than annually, the wage index and other adjustments. In addition, we must review the clinical integrity of payment groups and weights at least annually. Accordingly, in this proposed rule, we are proposing to update the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2007, as we discuss in sections II.C. and II.D., respectively, of this preamble. However, we are also proposing to reduce the update to the CY 2007 OPPS conversion factor by 2.0 percentage points for any hospital that is required to report quality data under the IPPS RHQDAPU for the FY 2007 update, and that fails to meet the requirements for receiving the full IPPS payment update in that payment year. We also are proposing to revise the relative APC payment weights using claims data from January 1, 2005, through December 31, 2005, and updated cost report information. In response to a provision in Pub. L. 108–173 that we analyze the cost of outpatient services in rural hospitals relative to urban hospitals, we are proposing to continue increased payments to rural SCHs, including EACHs. Section II.F. of this preamble provides greater detail on this rural adjustment. Finally, we are not proposing to remove any device categories from pass-through payment status in CY 2007.

Under this proposed rule, the update change to the conversion factor as provided by statute would increase total OPPS payments by 3.4 percent in CY 2007. The update change to the OPPS conversion factor for any hospital that is required to report quality data under the IPPS RHQDAPU for the FY 2007 update, but fails to meet the requirements for receiving the full IPPS payment update in that payment year would increase OPPS payments by 1.4 percent in CY 2007. The expiration of the one-time wage reclassification under section 508 in April 2007 which is not budget neutral and an increase in the fixed-dollar outlier threshold to account for the under estimation of outlier payments in CY 2006 results in a net increase of 3.0 percent. The proposed changes to the APC weights, changes to the wage indices, the continuation of a payment adjustment for rural SCHs, and the proposed expansion of the rural adjustment to EACHs would not increase OPPS payments because these changes to the OPPS are budget neutral. However, these updates do change the distribution of payments within the budget neutral system as shown in Table 49 and described in more detail in this section.

1. Alternatives Considered

Alternatives to the changes we are proposing to make and the reasons that we have chosen these 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 CPT Coding and Payment Policy for Evaluation and Management Codes

In section IX. of this preamble, we are proposing to create five new G-codes to replace CPT clinic E/M codes, five new G-codes for emergency visits provided in Type B emergency departments, five new G-codes for emergency visits provided in Type A emergency departments to replace CPT emergency department E/M codes, and two new G-codes to replace CPT critical care codes. CMS instructed hospitals to report facility resources for clinic and emergency department visits using CPT E/M codes and to develop internal hospital guidelines to determine what level of visit to report for each patient. However, since the beginning of the OPPS, we have acknowledged that the CPT E/M codes do not adequately describe the facility resources required to perform the services. Therefore, we are proposing G-codes to be used by hospitals to report clinic and emergency visits, and critical care services, which describe hospital resource use.

We acknowledge that it can be burdensome for providers to bill G-codes rather than CPT codes. CPT has not yet created clinic and emergency department visit and critical care services codes that describe hospital resource utilization. In this case, because the current CPT E/M codes do not describe hospital visit resources, we have no alternative other than to create new G-codes. It is important to note that G-codes may be recognized by other payers.

Some hospitals have requested that they be permitted to bill emergency visit codes under the OPPS for services furnished in a facility that meets CPT's definition for reporting emergency visit E/M codes, except that these hospitals are not available 24 hours a day. For CY 2007, we are proposing to establish a set of codes for visits provided in dedicated emergency departments that have an EMTALA obligation. These codes would be billed by Type B emergency departments, specifically those that do not meet the Type A requirements. We are also proposing to establish a separate set of codes for visits provided in a specific subset of dedicated emergency departments, called Type A emergency departments, that are open 24 hours per day, 7 days per week and/or that do not have an EMTALA obligation solely based on providing at least one-third of their outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment. An alternative to this policy is to continue to uphold past policy and allow only the Type A subset of dedicated emergency departments to bill emergency department codes. However, this would not allow us to determine whether visits to dedicated emergency departments or facilities that incur EMTALA obligations but do not meet more prescriptive expectations that are consistent with the CPT definition of an emergency department have different resource costs than visits to either clinics or the Type A subset of dedicated emergency departments that meet more prescriptive expectations, including 24 hours per day, 7 days per week availability.

We must also establish payment rates for these new G-codes. For CY 2007, we are proposing to pay at five payment levels for both clinic and emergency department visits and one payment level for critical care services. We see meaningful differences among the median costs of five levels of clinic and emergency department codes that

suggest that five payment levels are more appropriate than three levels. In addition, providers have indicated that it is administratively burdensome to code for five levels, but receive payment at only three levels, as has been the historical policy in the OPPS. If future data indicate that three payment levels are more appropriate, we may revert back to three payment levels. An alternative to this policy is to continue paying at three payment levels for both clinic and emergency department visits and one payment level for critical care services. However, for the reasons described above, we are proposing to pay at five levels for clinic and emergency department visits for CY 2007 to ensure that payments more accurately reflect the median costs of the services provided.

For CY 2007, we are proposing to pay emergency visits to Type B dedicated emergency departments that are not part of the specific subset identified as Type A emergency departments at the same rate as clinic visits, consistent with current policy. This payment policy is similar to our current policy that requires services furnished in emergency departments that have an EMTALA obligation but do not meet the CPT definition of emergency department to be reported using CPT clinic visit E/M codes, resulting in payments based upon clinic visit APCs. While maintaining the same payment policy for CY 2007, the reporting of specific G-codes for emergency visits provided in Type B dedicated emergency departments would permit us to specifically collect and analyze the hospital resource costs of visits to these facilities in order to determine whether a future proposal of an alternative payment policy may be warranted. An alternative would be to provide payment for services billed by Type B emergency departments at payment rates other than the clinic visit rates. However, we do not know what the hospital facility costs of these visits would be because we are unable to identify these services in our historical claims data. In some respects, their costs may resemble the costs of visits to clinics because they may not be available 24 hours per day or may not require the same high state of readiness as Type A emergency departments. In other respects, their costs may resemble the costs of visits to Type A emergency departments because they both provide predominantly unscheduled visits. Therefore, we currently would have no accurate methodology for establishing payment rates that are appropriate for visits to Type B emergency departments. Therefore, consistent with past payment policies for certain services, such as drug administration, in which we maintained current payment policies while gathering more detailed cost data, we are proposing to continue payment to Type B emergency departments at clinic visit rates while we gather hospital claims data specific to these visits to review their costs.

b. Options Considered for Brachytherapy Source Payments

Pursuant to sections 1833(t)(2)(H) and 1833(t)(16)(C) of the Act, we have paid for brachytherapy sources furnished on or after January 1, 2004, and before January 1, 2007, on a per source basis at an amount equal to the hospital's charge adjusted to cost by application of the hospital specific overall CCR. For CY 2007, we are proposing to pay for brachytherapy sources at a prospectively based rate for each source, which is assigned to a source-specific APC. We are proposing to convert the median cost to a relative weight by dividing it by the median for APC 0606, to scale the unscaled weight for budget neutrality, and to multiply the scaled weight by the conversion factor to calculate the payment rate per source. This is our standard OPPS methodology for using median costs to calculate the payment for each APC.

We considered establishing a per day payment for brachytherapy sources based on our CY 2005 claims data. While this alternative would be consistent with the philosophy of a prospective payment system and would mitigate the effects on payment of inaccurate coding of the number of sources used, we believe that a per day payment may not provide source payment variation specifically addressed to the hospital resources used under the unique clinical circumstances of each individual treatment. There is considerable clinical variation in the number of sources used for brachytherapy services, and we believe a per day payment based on an average number of sources used may not as accurately reflect appropriate payment for an individual Medicare beneficiary's treatment as the per source payment methodology. Therefore, we are not proposing to set payments on a per day basis.

We also considered continuing to make separate payment for sources of brachytherapy under the current methodology of hospital charges reduced to costs. Although hospitals are familiar with this methodology and this alternative is consistent with the requirement that sources be paid separately, we believe that to continue to pay on this basis would be inconsistent with the general methodology of a prospective payment system and would provide no incentive for a hospital to provide services efficiently and at the lowest cost. Therefore, for CY 2007, we are proposing to pay for each brachytherapy source on a per source rate that is calculated using our standard OPPS methodology.

c. Options Considered for Payment of Radiopharmaceuticals

In developing the payment policy proposal for separately payable radiopharmaceuticals for this CY 2007 proposed rule, we considered three policy options.

The first option we considered was to propose packaging additional radiopharmaceuticals, either through packaging payments for all radiopharmaceuticals with payments for the services with which they are billed or increasing the packaging threshold for radiopharmaceuticals from a cost of $55 per day to a higher amount. In contrast to other separately payable drugs where the administration of many drugs is reported with only a few drug administration HCPCS codes, only a small number of specific radiopharmaceuticals may be appropriately provided in the performance of each particular nuclear medicine procedure. Because the provision of nuclear medicine procedures always requires one or more radiopharmaceuticals, packaging more radiopharmaceuticals effectively results in some increases in the costs of the associated nuclear medicine procedures to reflect the greater packaging of the radiopharmaceuticals. A policy to package additional radiopharmaceuticals would be very consistent with the OPPS packaging principles and payment policies which generally provide appropriate payment for the ''average'' service and would provide greater administrative simplicity for hospitals. However, under a policy of increased packaging of radiopharmaceuticals, payments for certain nuclear medicine procedures could potentially be less than the costs of some of the packaged radiopharmaceuticals and relatively expensive and high volume radiopharmaceuticals could become packaged. In addition, our payment policy could discourage selection of the most clinically appropriate radiopharmaceutical for a particular nuclear medicine procedure, especially if that radiopharmaceutical were expensive and not commonly used so that its costs were not fully reflected in

the payment for the nuclear medicine procedure.

The second option that we considered was to propose to continue the temporary CY 2006 methodology of paying for separately payable radiopharmaceuticals at charges reduced to cost, where payment would be determined using each hospital's overall CCR, and establishing our radiopharmaceutical packaging threshold at $55, as we are proposing for other drugs for the CY 2007 OPPS. This policy would provide stability to the payment methodology for radiopharmaceuticals from CY 2006 to CY 2007. As we indicated for CY 2007, this payment methodology would provide an acceptable proxy for the average acquisition of the radiopharmaceutical along with its handling cost. However, as indicated previously, we stated in the CY 2006 final rule with comment period that this payment policy was intended to be only a temporary policy, and that we would consider alternative methodologies on which to base radiopharmaceutical payments for the CY 2007 OPPS update. Paying for radiopharmaceuticals at cost provides hospitals with no incentive to supply radiopharmaceuticals in the most efficient manner. In addition, using hospitals' overall CCRs to determine payments likely results in an overestimation of radiopharmaceutical cost, which are likely reported in several cost centers such as diagnostic radiology that have lower CCRs than hospitals' overall CCRs.

The third option that we considered and are proposing for CY 2007 is to establish prospective payment rates for separately payable radiopharmaceuticals using mean costs derived from the CY 2005 claims data, where the costs are determined using our standard methodology of applying hospital-specific departmental CCRs to radiopharmaceutical charges and defaulting to hospital-specific overall CCRs only if appropriate departmental CCRs are unavailable. This proposal establishes our packaging threshold for radiopharmaceuticals at $55, as proposed for other drugs under the CY 2007 OPPS. We believe this option provides us with the most consistent, accurate, and efficient methodology for prospectively establishing payment rates for separately payable radiopharmaceuticals; in addition, this proposed methodology is consistent with how payment rates for other services are determined under the OPPS and provides for prospective payments that serve as appropriate proxies for the average acquisition costs of the radiopharmaceuticals along with their handling costs.

2. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the policy changes, as well as the statutory changes that would be effective for CY 2007, on various hospital groups. We estimate the effects of individual policy changes by estimating payments per service while holding all other payment policies constant. We use the best data available but do not attempt to predict behavioral responses to our policy changes. In addition, we do not make adjustments for future changes in variables such as service volume, service-mix, or number of encounters. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effect of these proposed changes on hospitals and our methodology for estimating them.

One limitation of our analysis in this proposed rule is that we are unable at this time to estimate the impact of our proposal to reduce the update to the CY 2007 OPPS conversion factor by 2.0 percentage points for any hospital that is required to report quality data under the IPPS RHQDAPU for the FY 2007 update, and that fails to meet the requirements for receiving the full IPPS payment update in that payment year. As we discuss in section XXIII of the preamble of this proposed rule, we are unable at this time to determine how many hospitals will receive a reduced update in CY 2007. Determinations concerning which hospitals have failed to meet the requirements for receiving the full update to the OPPS conversion factor in CY 2007 will only become available on or about September 1, 2006.

Experience with mandatory reporting of quality data under the IPPS RHQAPU indicates that only a small number of hospitals have failed to meet the requirements to receive the full update to their payments under the IPPS. However, the statute requires that the reduction to the update for those IPPS hospitals that fail to meet the quality reporting requirement will increase from 0.4 percentage point to 2.0 percentage points for purposes of payment in FY 2007. This increase in the size of the update reduction significantly increases the already strong incentive to submit quality data. We therefore believe that the already small number of hospitals that fail to meet the requirements for receiving the full update may actually decrease significantly. We expect that only very few, if any, hospitals will fail to receive the full update to the OPPS conversion factor in CY 2007. However, due to the uncertainty concerning the degree to which the increased incentive to report quality data will affect hospital behavior, we are unable to predict with any confidence the number of hospitals that will receive the reduced update under the OPPS RHQDAPU, or to incorporate any specific data concerning the impact of this proposal into impact Table 49 below.

We are also unable to determine the budget neutrality adjustment factor that will be necessary to ensure that estimated aggregate payments under the OPPS for CY 2007 do not change as a result of implementing the proposed OPPS RHQDAPU. We also expect, however, that the distributional impact of the proposal will be quite minimal. We also expect that any budget neutrality adjustment that we determine to be necessary once the determinations concerning compliance with the quality data reporting requirements become available will be correspondingly negligible. At the same time, any hospital that has reason to believe that it will not meet the requirements for receiving a full update under our proposal should be able to assess the potential impact of receiving the reduced update, simply by estimating the payments that the hospital will receive using the reduced conversion factor of $60.36, reflecting an update of 1.4 percent, in place of the conversion factor of $61.551 reflecting the full proposed update of 3.4 percent. Over time, the proposed OPPS RHQDAPU may have a discernible, positive impact on the quality of care available to Medicare beneficiaries in hospital outpatient departments. Meanwhile, the impact analysis below assumes that there will be full compliance with the requirements of the proposed OPPS RHQDAPU for purposes of receiving the full update in CY 2007, that all OPPS outpatient departments will therefore receive payments reflecting the full update in CY 2007, and that no additional adjustment to the OPP conversion factor will be necessary to ensure budget neutrality in CY 2007.

3. Estimated Impacts of This Proposed Rule on Hospitals

The estimated increase in the total payments made under the OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service-mix. The enactment of Pub. L. 108–173 on December 8, 2003, provided for the additional payment outside of the budget

neutrality requirement for wage indices for specific hospitals reclassified under section 508 through CY 2007. Table 49 shows the estimated redistribution of hospital payments among providers as a result of a new APC structure, wage indices, and proposed adjustment for rural SCHs and EACHs, which are budget neutral; the estimated distribution of increased payments in CY 2007 resulting from the combined impact of the proposed APC recalibration, wage effects, the rural SCH and EACH adjustment, and the proposed market basket update to the conversion factor; and, finally, estimated payments considering all proposed payments for CY 2007 relative to all payments for CY 2006, including the impact of expiring wage provisions and changes in the outlier threshold. Because updates to the conversion factor, including the update of the market basket and the addition of money not dedicated to pass-through payments are applied uniformly, observed redistributions of payments in the impact table largely depends on the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change), the impact of the wage index changes on the hospital, and the impact of the payment adjustment for rural SCHs, including EACHs. However, total payments made under this system and the extent to which this proposed rule would redistribute money during implementation also would depend on changes in volume, practice patterns, and the mix of services billed between CY 2006 and CY 2007, which CMS cannot forecast. Overall, the proposed OPPS rates for CY 2007 would have a positive effect for all hospitals paid under the OPPS. Proposed changes would result in a 3.0 percent increase in Medicare payments to all hospitals, exclusive of transitional pass-through payments. Removing cancer and children's hospitals because their payments are held harmless to the pre-BBA ratio between payment and cost suggests that proposed changes would result in a 3.1 percent increase in Medicare payments to all other hospitals.

To illustrate the impact of the proposed CY 2007 changes, our analysis begins with a baseline simulation model that uses the final CY 2006 weights, the FY 2006 final post-reclassification IPPS wage indices without additional increases resulting from section 508 reclassifications, and the final CY 2006 conversion factor. Column 2 in Table 49 reflects the independent effects of the proposed APC reclassification and recalibration changes. Column 3 reflects the effects of updated wage indices, and the adjustment for rural SCHs and EACHs. The clarification that the rural adjustment applies to EACHs is not shown separately because there are so few EACHs that the overall impact cannot be observed when payments are aggregated by type of hospital. These effects are budget neutral, which is apparent in the overall zero impact in payment for all hospitals in the top row. Column 2 shows the independent effect of changes resulting from the proposed reclassification of services codes among APC groups and the proposed recalibration of APC weights based on a complete year of CY 2005 hospital OPPS claims data and more recent cost report data. We modeled the independent effect of APC recalibration by varying only the weights, the final CY 2006 weights versus the proposed CY 2007 weights, in our baseline model, and calculating the percent difference in payments.

Column 3 shows the impact of updating the wage index used to calculate payment by applying the proposed FY 2007 IPPS wage index, combined with the impact of the proposed 7.1 percent rural adjustment for SCHs and EACHs for services other than drugs, biologicals, brachytherapy sources, and those receiving pass-through payments. The OPPS wage index used in Column 3 does not include changes to the wage index for hospitals reclassified under section 508 of Pub. L. 108–173. We modeled the independent effect of updating the wage index and the rural adjustment by varying only the wage index and the inclusion of EACHs, using the proposed CY 2007 scaled weights, and a CY 2006 conversion factor that included a budget neutrality adjustment for changes in wage effects and the rural adjustment between CY 2006 and CY 2007.

Column 4 demonstrates the combined ''budget neutral'' impact of proposed APC recalibration, the wage index update, and the proposed rural adjustment for rural SCHs and EACHs on various classes of hospitals, as well as the impact of updating the conversion factor with the market basket update. We modeled the independent effect of proposed budget neutrality adjustments and the market basket update by using the weights and wage indices for each year, and using a CY 2006 conversion factor that included the proposed market basket update and budget neutrality adjustments for differences in wages and the adjustment for rural SCHs and EACHs.

Finally, Column 5 depicts the full impact of the proposed CY 2007 policy on each hospital group by including the effect of all the proposed changes for CY 2007 and comparing them to all estimated payments in CY 2006, including those required by Pub. L. 108–173. Column 5 shows the combined budget neutral effects of Columns 2 through 4, plus the impact of increasing the outlier threshold after realigning the overall CCR calculation used to model the outlier threshold with the one used by the fiscal intermediary for payment, the impact of changing the percentage of total payments dedicated to transitional pass-through payments to 0.13 percent, and the expiration of payment for wage index increases for hospitals reclassified under section 508 of Pub. L. 108–173 in April 2007. As noted in section II.D. of this preamble, because section 508 expires in April 2007 and OPPS operates on a calendar year basis, we used a blended wage index consisting of 25 percent of the IPPS wage index with section 508 and 75 percent of the IPPS wage index after section 508 expires.

We modeled the independent effect of all changes in Column 5 using the final weights for CY 2006 and the proposed weights for CY 2007. The wage indices in each year include wage index increases for hospitals eligible for reclassification under section 508 of Pub. L. 108–173, and in 2007, these provisions expire in April 2007. We used the final conversion factor for CY 2006 of $59.511 and the proposed CY 2007 conversion factor of $61.551. Column 5 also contains simulated outlier payments for each year. We used the charge inflation factor used in the proposed FY 2007 IPPS rule of 7.57 percent (1.0757) to increase individual costs on the CY 2005 claims to reflect CY 2006 dollars, and we used the most recent overall CCR for each hospital as calculated for the APC median setting process. Using the CY 2005 claims and a 7.57 percent charge inflation factor, we currently estimate that actual outlier payments for CY 2006, using a multiple threshold of 1.75 and a fixed-dollar threshold of $1,250 would be 1.25 percent of total payments, which is 0.25 percent higher than the 1.0 percent that we projected in setting outlier policies for CY 2006, due to the differences in the calculation of the overall CCR, as discussed in section II.A.1.c. of this preamble. Outlier payments of 1.25 percent appear in the CY 2006 comparison in Column 5. We used the same set of claims and a charge inflation factor of 15.15 percent (1.1515) to model the CY 2007 outliers at 1.0 percent of total payments using a multiple

threshold of 1.75 and a proposed fixed-dollar threshold of $1,825.

Column 1: Total Number of Hospitals

Column 1 in Table 49 shows the total number of hospital providers (3,922) for which we were able to use CY 2005 hospital outpatient claims to model CY 2006 and CY 2007 payments by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2006 or CY 2007 payment and entities that are not paid under the OPPS. The latter entities include CAHs, all-inclusive hospitals, and hospitals located in Guam, the U.S. Virgin Islands, Northern Marianas, American Samoa, and the State of Maryland. This process is discussed in greater detail in section II.A. of this preamble. At this time, we are unable to calculate a disproportionate share (DSH) variable for hospitals not participating in the IPPS. Hospitals for which we do not have a DSH variable are grouped separately and generally include psychiatric hospitals, rehabilitation hospitals, and LTCHs. Finally, section 1833(t)(7)(D) of the Act permanently holds harmless cancer hospitals and children's hospitals to the proportion of their pre-BBA payment relative to their costs. Because this proposed rule would not impact these hospitals negatively, we removed them from our impact analyses. We show the total number (3,864) of OPPS hospitals, excluding the hold-harmless cancer hospitals and children's hospitals, on the second line of the table.

Column 2: APC Recalibration

The combined effect of the proposed APC reclassification and recalibration, in Column 2 are typical for APC recalibration. Overall, these changes have no impact on all urban hospitals, which show no projected change in payments, although some classes of urban hospitals experience decreases in payments. However, changes to the APC structure for CY 2007 tend to favor, slightly, urban hospitals that are not located in large urban areas. We estimate that large urban hospitals would experience a decline of 0.1 percent, while ''other'' urban hospitals experience an increase of 0.1 percent. Urban hospitals with between 0 and 299 beds experience increases, while the largest urban hospitals, those with beds greater than 299 experience decreases of 0.1 to 0.2 percent. With regard to volume, all urban hospitals except those with volume less than 11,000 lines, experience increases in payments. The lowest volume hospitals experience the largest decrease of 7.1 percent, largely as a result of decreases in payment for partial hospitalization and psychotherapy services. Urban hospitals providing the highest volume of services demonstrate no projected change as a result of APC recalibration. Estimated decreases in payment for urban hospitals are also concentrated in some regions, specifically, Middle Atlantic, West North Central, and Pacific, with decreases of 0.3, 0.4, and 0.2 percent respectively. On the other hand, most other regions experience moderate increases and urban hospitals in the East South Central and New England experience no change as a result of APC recalibration.

Overall, rural hospitals show a modest 0.1 percent increase as a result of changes to the APC structure, and this 0.1 percent increase appears to be concentrated in rural hospitals that are not rural SCHs, which experience a 0.2 percent increase. Notwithstanding a modest overall increase in payments, there is substantial variation among classes of rural hospitals. Specifically, rural hospitals with more than 199 beds experience a decrease of 0.1 percent and rural hospitals with 150–199 beds experience the largest increase of 0.3 percent. With regard to volume, all rural hospitals, except those with the lowest volume, experience increases in payments. The lowest volume hospitals experience the largest decrease of 3.5 percent. Rural hospitals with greater than 5,000 lines of volume demonstrate projected increases of 0.1 to 0.4 percent as a result of APC recalibration. Increases ranging from 0.2 to 0.5 percent occur for rural hospitals in every region except New England, the Middle Atlantic, and the West North Central. The largest decreases are observed in New England (−0.5 percent), Middle Atlantic (−0.5), West North Central (−0.2 percent) regions.

Among other classes of hospitals, the largest observed impacts resulting from APC recalibration include an increase of 0.1 percent for nonteaching hospitals and a decrease of 0.3 percent for major teaching hospitals. Urban hospitals that are treating DSH patients and are also teaching hospitals experience decreases of 0.1 percent. We project that hospitals for which a DSH percentage is not available, including psychiatric hospitals, rehabilitation hospitals, and long-term care hospitals would experience decreases in payments of 8.9 percent, and for the urban subset, 9.2 percent, largely as a result of proposed changes to partial hospitalization and psychotherapy payments.

Classifying hospitals by type of ownership suggests that proprietary hospitals would gain 0.4 percent, while governmental and voluntary hospitals would experience neither gains nor losses (0.0 percent change).

Column 3: New Wage Indices and the Effect of the Rural Adjustment

Changes introduced by the proposed FY 2007 IPPS wage indices together with the effect of including EACHs in the rural adjustment would have a modest impact in CY 2007, decreasing payments to rural hospitals other than SCHs slightly and having no effect overall on urban hospitals. We estimate that rural SCHs would experience an increase in payments of 0.1 percent, while all other rural hospitals experience a decrease of 0.2 percent. With respect to volume, rural hospitals with moderate volume experience decreases of 0.2 percent. For both facility size and volume, no category of rural hospitals experiences an increase greater than 0.2 percent. Examining hospitals by region reveals slightly greater variability. We estimate that rural hospitals in several regions would experience decreases in payment up to 0.7 percent due to wage changes, including New England, East South Central, South Atlantic, Mountain, and West South Central regions. However, rural hospitals in the remaining regions experience increases. We estimate that the Pacific region would see the largest increase of 0.6 percent.

Overall, urban hospitals experience no change in payments as a result of the new wage indices and the rural adjustment. With respect to facility size, we estimate that urban hospitals with less than 100 and greater than 499 beds would experience a decrease in payments of 0.1 percent. Urban hospitals with 100–299 beds experience no change. Urban hospitals with between 300–499 beds have the largest increase of 0.1 percent. When categorized by volume, urban hospitals with the largest volume experience no change in payment as a result of changes to the wage index and the presence of the rural adjustment, and urban hospitals with the lowest volume experience a 0.2 percent increase in payment. We estimate that urban hospitals in the South Atlantic, East South Central, and West South Central regions would experience modest decreases due to wage changes and the effect of the rural adjustment of no more than 0.3 percent (except for urban hospitals in Puerto Rico, with a decrease of 1.8 percent). Urban hospitals in all other regions (except New England) would experience an increase of 0.1 to 0.7 percent. Urban hospitals in the New England region would experience no change in payments.

Looking across other categories of hospitals, we estimate that updating the wage index and continuing the rural adjustment would lead major teaching hospitals to gain 0.1 percent and hospitals without graduate medical education programs are estimated to lose 0.1 percent. Hospitals serving 23–35 percent low-income patients are estimated to gain 0.1 percent. Hospitals serving no low-income patients, for which the percent of low-income patients cannot be determined and those serving more than 35 percent low-income patients lose 0.1 percent, whereas hospitals serving other percentages of low-income patients experience no change. Voluntary hospitals as classes would experience no change in payment due to wage changes and the effect of the rural adjustment. Governmental and proprietary hospitals would lose 0.1 percent.

Column 4: All Budget Neutrality Changes and Market Basket Update

The addition of the market basket update alleviates any negative impacts on payments for CY 2007 created by the budget neutrality adjustments made in Columns 2, and 3, with the exception of urban hospitals with the lowest volume of services and hospitals not paid under IPPS, including psychiatric hospitals, rehabilitation hospitals, and LTCHs (DSH not available). In many instances, the redistribution of payments created by proposed APC recalibration offset those introduced by updating the wage indices. However, in a few instances, negative APC recalibration changes compound a reduction in payment from updating the wage index.

We estimate that the cumulative impact of the budget neutrality adjustments and the addition of the market basket update would result in an increase in payments for urban hospitals of 3.4 percent, which is equal to the market basket update of 3.4 percent. Large urban hospitals would experience an increase of 3.3 percent and other urban hospitals would experience an increase of 3.6 percent. Urban hospitals with the lowest volume experience a negative market basket update, which is largely a function of the 7.1 percent decrease in payments attributable to changes to the APC structure. Urban hospitals with moderate volume have an increase of 2.3 percent while urban hospitals with volumes greater than 10,999 lines have increases of 3.4 to 3.5 percent. When we examine the impact of the cumulative effect of APC changes, wage index and rural adjustment changes, and the market basket on urban hospitals by region, we see that urban hospitals in five regions (New England, East North Central, West South Central, Mountain, and Pacific) would experience an increase that is equal to or higher than the market basket increase. Hospitals in the remaining five regions (Middle Atlantic, South Atlantic, East South Central, West North Central, and Puerto Rico) receive an increase that is less than the market basket.

We estimate that the cumulative impact of budget neutrality adjustments and the market basket update would result in an overall increase for rural hospitals of 3.4 percent, with rural SCHs experiencing an update of 3.4 percent and other rural hospitals also experiencing an update of 3.4 percent. In general, rural hospitals with less than 200 beds and rural hospitals with more than 5,000 lines of volume experience increases equal to or greater than the market basket update of 3.4 percent. We estimate that low-volume rural hospitals would experience no change (0.0 percent). Rural hospitals demonstrate variability by region. We estimate that four regions (East North Central, West North Central, West South Central, and Pacific) would experience increases larger than the market basket update. We also estimate that rural hospitals in the five remaining regions (New England, Middle Atlantic, South Atlantic, East South Central, and Mountain) would receive increases that would be less than the market basket increase.

The changes across columns for other classes of hospitals are fairly moderate and most show updates relatively close to the market basket update with the exception of hospitals not paid under the IPPS. These hospitals show negative payment updates as a result of changes to payment rates for partial hospitalization and psychotherapy services. Voluntary, proprietary and governmental hospitals also show an increase equal to or greater than the market basket.

Column 5: All Proposed Changes for CY 2007

Column 5 compares all proposed changes for CY 2007 to final payment for CY 2006 and includes any additional dollars resulting from provisions in Pub. L. 108–173 in both years, changes in outlier payment percentages and thresholds, and the difference in pass-through estimates. Overall, we estimate that hospitals would gain 3.0 percent under this proposed rule in CY 2007 relative to total spending in CY 2006. When we excluded cancer and children's hospitals, which are held harmless, the gain is 3.1 percent. While hospitals would receive the 3.4 percent increase due to the market basket update appearing in Column 4 and the additional 0.04 percent for the reduction in the pass-through estimate between CY 2006 and CY 2007, we estimate that hospitals also experience a 0.25 percent loss due to outlier payments as a result of the increased threshold and the change to the overall CCR that is used to estimate outlier payments. In addition, there is a loss of 0.17 percent as a result of the expiration of the section 508 wage adjustment.

In general, urban hospitals appear to experience the largest negative impacts from the combined effects of these factors. We estimate that hospitals in large urban areas would gain 3.0 percent in CY 2007 and hospitals in other urban areas would gain 3.1 percent. We estimate that low-volume urban hospitals would experience a decrease in total payments of 3.2 percent between CY 2006 and CY 2007, largely as a result of changes to payment for partial hospitalization, psychotherapy and radiation therapy services. Hospitals reporting 5,000 to 10,999 lines of volume show an increase of 1.9 percent but all hospitals with volume larger than 10,999 lines have increases equal to or greater than 3.1 percent. Urban hospitals in all regions other than the Mountain region have overall increases that are less than the market basket increase and which range from 2.5 to 3.3 percent. Urban hospitals in the Mountain region are estimated to receive the largest increases for urban hospitals of 4.1 percent.

Overall, rural hospitals experience increases similar to those observed for urban hospitals. Overall, we estimate that rural hospitals would experience an increase in payments of 3.1 percent, which is identical to the 3.1 percent increase we project for all hospitals when we exclude the 58 hospitals that are held harmless under the law. However, we also estimate that rural SCHs would experience an increase of 2.8 percent, and that the other rural hospitals would only experience an increase of 3.3 percent. No category of rural hospitals experiences a decrease in payments between CY 2006 and CY 2007, and rural hospitals in a few regions show increases comparable to, or better than, the market basket. Rural hospitals with fewer than 150 beds and rural hospitals with volumes greater than 4,999 lines experience increases of at least 3.0 percent, the national average overall increase for all hospitals. Across the regions, rural hospitals in five regions (South Atlantic, East North Central, East South Central, West South Central, and Pacific) are projected to

receive increases equal to or greater than the projected 3.0 percent increase for all hospitals. Rural hospitals in four regions (New England, Middle Atlantic, West North Central, and Mountain) are projected to receive overall increases that are less than the projected increase for all hospitals. We project that low-volume rural hospitals would experience the lowest increase in overall payment of 0.8 percent (due largely to changes in payment for partial hospitalization, psychotherapy, and radiation therapy services).

Among other classes of hospitals, we estimate that hospitals not paid under the IPPS (DSH Not Available) would experience decreases in payments between CY 2006 and CY 2007 of 5.4 percent. We estimate that major teaching hospitals would experience an increase of 2.6 percent and that nonteaching hospitals would experience an increase of 3.2 percent.

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Table 49.--Impact of Proposed Changes for CY 2007 Hospital Outpatient Prospective Payment System

	(1)	(2)	(3)	(4)	(5)
	Number of Hospitals	APC Changes	New Wage Index and Rural Adjustment	Cumulative (Cols 2,3,4) with Market Basket Update	All Changes
ALL HOSPITALS[1]	3922	0.0	0.0	3.4	3.0
ALL HOSPITALS (excludes hospitals held harmless)	3864	0.0	0.0	3.4	3.1
URBAN HOSPITALS	2846	0.0	0.0	3.4	3.0
LARGE URBAN (GT 1 MILL.)	1563	-0.1	0.0	3.3	3.0
OTHER URBAN (LE 1 MILL.)	1283	0.1	0.1	3.6	3.1
RURAL HOSPITALS	1018	0.1	-0.1	3.4	3.1
SOLE COMMUNITY	414	0.0	0.1	3.4	2.8
OTHER RURAL	604	0.2	-0.2	3.4	3.3
BEDS (URBAN)					
0 - 99 BEDS	893	0.1	-0.1	3.4	3.1
100-199 BEDS	908	0.1	0.0	3.5	3.1
200-299 BEDS	477	0.2	0.0	3.6	3.3
300-499 BEDS	404	-0.1	0.1	3.4	3.0
500 + BEDS	164	-0.2	-0.1	3.2	2.7
BEDS (RURAL)					
0 - 49 BEDS	362	0.0	0.0	3.5	3.1
50- 100 BEDS	381	0.1	-0.1	3.4	3.2
101- 149 BEDS	164	0.2	0.0	3.5	3.3
150- 199 BEDS	65	0.3	-0.3	3.4	2.9
200 + BEDS	46	-0.1	-0.1	3.3	2.5
VOLUME (URBAN)					
LT 5,000 Lines	537	-7.1	0.2	-3.5	-3.2
5,000 - 10,999 Lines	168	-0.9	-0.2	2.3	1.9
11,000 - 20,999 Lines	253	0.1	-0.1	3.4	3.2
21,000 - 42,999 Lines	564	0.2	-0.1	3.5	3.2
GT 42,999 Lines	1324	0.0	0.0	3.5	3.1
VOLUME (RURAL)					
LT 5,000 Lines	90	-3.5	0.1	0.0	0.8
5,000 - 10,999 Lines	104	0.3	0.2	3.8	3.3
11,000 - 20,999 Lines	226	0.4	-0.2	3.6	3.1
21,000 - 42,999 Lines	315	0.2	-0.2	3.4	3.3
GT 42,999 Lines	283	0.1	0.0	3.4	3.0
REGION (URBAN)					
NEW ENGLAND	159	0.0	0.0	3.4	2.7
MIDDLE ATLANTIC	372	-0.3	0.1	3.2	2.5
SOUTH ATLANTIC	442	0.1	-0.3	3.2	3.0
EAST NORTH CENTRAL	441	0.1	0.2	3.7	3.3
EAST SOUTH CENTRAL	186	0.0	-0.2	3.1	3.0
WEST NORTH CENTRAL	179	-0.4	0.1	3.0	2.8
WEST SOUTH CENTRAL	443	0.4	-0.3	3.6	3.3
MOUNTAIN	179	0.1	0.7	4.2	4.1

	(1) Number of Hospitals	(2) APC Changes	(3) New Wage Index and Rural Adjustment	(4) Cumulative (Cols 2,3,4) with Market Basket Update	(5) All Changes
PACIFIC	393	-0.2	0.2	3.4	3.0
PUERTO RICO	52	1.0	-1.8	2.7	2.7
REGION (RURAL)					
NEW ENGLAND	21	-0.5	-0.1	2.8	2.6
MIDDLE ATLANTIC	73	-0.5	0.1	3.0	2.8
SOUTH ATLANTIC	174	0.2	-0.4	3.2	3.1
EAST NORTH CENTRAL	125	0.3	0.2	3.8	3.3
EAST SOUTH CENTRAL	183	0.3	-0.4	3.2	3.2
WEST NORTH CENTRAL	120	-0.2	0.5	3.6	2.7
WEST SOUTH CENTRAL	198	0.5	-0.3	3.6	3.5
MOUNTAIN	79	0.5	-0.7	3.2	2.8
PACIFIC	45	0.2	0.6	4.3	3.6
TEACHING STATUS					
NON-TEACHING	2835	0.1	-0.1	3.5	3.2
MINOR	749	0.0	0.0	3.4	3.0
MAJOR	280	-0.3	0.1	3.3	2.6
DSH PATIENT PERCENT					
0	10	0.6	-0.1	3.9	3.7
GT 0 - 0.10	382	0.1	0.0	3.5	3.3
0.10 - 0.16	482	0.1	0.0	3.5	3.1
0.16 - 0.23	772	0.1	0.0	3.5	3.0
0.23 - 0.35	917	0.1	0.1	3.5	3.2
GE 0.35	778	0.0	-0.1	3.3	3.0
DSH NOT AVAILABLE[2]	523	-8.9	-0.1	-5.6	-5.4
URBAN TEACHING/DSH					
TEACHING & DSH	928	-0.1	0.1	3.4	3.0
NO TEACHING/DSH	1410	0.3	-0.1	3.6	3.3
NO TEACHING/NO DSH	9	0.5	-0.1	3.7	3.6
DSH NOT AVAILABLE[2]	499	-9.2	-0.2	-6.0	-5.7
TYPE OF OWNERSHIP					
VOLUNTARY	2163	0.0	0.0	3.4	3.0
PROPRIETARY	1111	0.4	-0.1	3.6	3.5
GOVERNMENT	590	0.0	-0.1	3.4	3.0

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 CY 2005 hospital claims data.
Column (3) shows the budget neutral impact of updating the wage index and rural adjustment by applying the proposed FY 2007 hospital inpatient wage index and making EACHs eligible for the rural adjustment.
Column (4) shows the impact of all budget neutrality adjustments and the addition of the market basket update.
Column (5) shows the additional adjustments to the conversion factor resulting from a change in the pass-through estimate, and adds outlier payments. The change in outlier payments reflects an increase in the fixed-dollar threshold to accommodate a change in the overall CCR calculation. This column also shows the impact of the expiring section 508 wage reclassification provision, which ends in April 2007.
[1]These 3,922 hospitals include children and cancer hospitals, which are held harmless to pre-BBA payments.
[2]Complete DSH numbers are not available for providers that are not paid under the IPPS, including rehabilitation, psychiatric, and LTCHs.

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4. Estimated Effect of This Proposed Rule on Beneficiaries

For services for which the beneficiary pays a copayment of 20 percent of the payment rate, the beneficiary share of payment would increase for services for which OPPS payments would rise and would decrease for services for which OPPS payments would fall. For example, for an electrocardiogram (APC 0099), the minimum unadjusted copayment in CY 2006 was $4.49. In this proposed rule, the minimum unadjusted copayment for APC 0099 is $4.72 because the OPPS payment for the service would increase under this proposed rule. In another example, for a Level IV Needle Biopsy (APC 0037), in the CY 2006 OPPS, the national unadjusted copayment in CY 2006 was $228.76, and the minimum unadjusted copayment was $114.38. In this

proposed rule, the national unadjusted copayment for APC 0037 is $228.76. The minimum unadjusted copayment for APC 0037 is $126.32, or 20 percent of the proposed payment for APC 0037. In all cases, the statute limits beneficiary liability for copayment for a service to the inpatient hospital deductible for the applicable year. For 2006, the inpatient deductible is $962.

In order to better understand the impact of changes in copayment on beneficiaries, we modeled the percent change in total copayment liability using CY 2005 claims. We estimate, using the claims of the 3,922 hospitals on which our modeling is based, that total beneficiary liability for copayments would decline as an overall percentage of total payments from 27.5 percent in CY 2006 (revised from 29 percent that we estimated for CY 2006 in the November 1, 2005 final rule with comment period 70 FR 68727) to 26.3 percent in CY 2007. This estimated decline in beneficiary liability is a consequence of the APC recalibration and reconfiguration we are proposing for CY 2007. In particular, the proposed changes to the emergency department visit APCs would set the copayments for these high volume services to 20 percent of the proposed payment rates, resulting in a significant reduction in beneficiary copayments.

5. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*, in Table 50 below, we have prepared an accounting statement showing the classification of the expenditures associated with the OPPS provisions of this proposed rule. This table provides our best estimate of the increase in Medicare payments under the OPPS as a result of the changes presented in this proposed rule on the data for 3,922 hospitals. All expenditures are classified as transfers to Medicare providers (that is, OPPS).

TABLE 50.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM CY 2006 TO CY 2007

Category	Transfers
Annualized Monetized Transfers	$1.0 Billion.
From Whom to Whom	Federal Government to OPPS Medicare Providers.
Category	Transfers.
Annualized Monetized Transfer	$250 Million.
From Whom to Whom	Increase in Premium Payments from Beneficiaries to Federal Government.
Total	$750 Million.

6. Conclusion

The changes in this proposed rule would affect all classes of hospitals. Some hospitals experience significant gains and others less significant gains, but almost all hospitals would experience positive updates in OPPS payments in CY 2007. Table 49 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements and an additional 3.0 percent increase in payments for CY 2007, after considering the proposed market basket increase, the cost of outliers, changes to the pass-through estimate and the elimination of the section 508 adjustment of Pub. L. 108–173. The accompanying discussion, in combination with the rest of this proposed rule,2 constitutes a regulatory impact analysis.

C. Effects of Proposed Changes to the ASC Payment System for CY 2007

(If you choose to comment on issues in the section, please include the caption ''CY 2007 ASC Impact'' at the beginning of your comment.)

We are proposing to add 14 surgical procedures to the Medicare list of ASC payable services and to implement section 5103 of Pub. L. 109–171, which requires the Secretary to substitute the OPPS payment amount for the ASC standard overhead amount if the standard overhead amount for facility services for surgical procedures performed in an ASC, without application of any geographic adjustment, exceeds the Medicare OPPS payment amount for the service for that year, without application of any geographic adjustment. This provision applies to surgical procedures furnished in ASCs on or after January 1, 2007, and before the effective date of the revised ASC payment system. Except for the payment changes required under section 5103 of Pub. L. 109–171, we are proposing no changes in CY 2007 to the ASC payment rates that are currently in effect.

The Office of the Actuary estimates that adding the 14 procedures we are proposing in section XVII. of this preamble and implementing the Pub. L. 109–171 mandate would result in a savings to the Medicare program of approximately $150 million in CY 2007.

1. Alternatives Considered

We are issuing this proposed rule to meet a statutory requirement that we update the list of approved ASC procedures at least every two years. We implement the biennial update of the list through notice and comment in the **Federal Register** to give interested parties an opportunity to review and comment on proposed additions to and deletions from the ASC list. The last update of the ASC list through notice and comment was effective July 5, 2005. However, the statute requires us to update the list at least every 2 years, which means we must update the list by July 2007.

2. Limitations of Our Analysis

Without datasets related to classes of ASCs which parallel the data maintained in the Medicare provider-specific files for hospitals, we cannot model distributional impacts of the proposed CY 2007 changes in the ASC list and ASC payments similar to those we prepare for our OPPS impact analysis (see Table 49). The actuarial estimate of Medicare program costs or savings resulting from the update of the ASC list and implementation of section 5103 of Pub. L. 109–171 in CY 2007 is based on estimated CY 2007 utilization. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effect of these changes that we are proposing for CY 2007 to gauge their impact on individual ASCs.

3. Estimated Effects of This Proposed Rule on ASCs

The CMS Office of the Actuary estimates that approximately 25 percent of the cases currently reported by hospitals using the 14 codes we are proposing to add to the ASC list would shift to the ASC setting in CY 2007. It estimates that the shift of these procedures to the less costly ASC setting

would result in modest savings for the Medicare program.

Savings would also be realized because section 5103 of the Pub. L. 109–171 would impose a payment limit for 81 procedures on the current ASC list. The Office of the Actuary estimates that adding 14 surgical procedures to the ASC list and capping payment for 81 procedures on the current ASC list would result in a combined savings to the Medicare program of approximately $150 million in CY 2007. We have not estimated the impact of our proposed changes for CY 2007 on Medicare expenditures in subsequent years because we are proposing to implement an entirely revised payment system in CY 2008. Our analysis of the impact of that proposed payment system is discussed in section XXVII.D.

Currently, Medicare pays a facility fee to ASCs only for those procedures that have been approved for the ASC list. The addition of 14 surgical procedures to the ASC list would be beneficial to ASCs by making it possible for them to offer more surgical procedures to Medicare beneficiaries. We believe that approximately 25 percent of the annual hospital outpatient volume of the 14 procedures proposed for addition to the ASC list would move to the ASC setting in CY 2007. To the extent that hospital outpatient utilization decreases and ASC utilization increases in CY 2007, the Medicare program would realize a savings because the ASC standard overhead amount for all procedures, including the proposed additions to the ASC list, would be equal to or lower than the payment rate for the same procedures under the OPPS. Because hospitals perform a much higher volume of ambulatory surgeries overall than are performed in ASCs, we do not expect significant hospital revenue losses to result from migration of procedures that we are proposing for addition to the ASC list to the ASC setting.

4. Estimated Effects of This Proposed Rule on Beneficiaries

The proposed changes for CY 2007 would be positive for beneficiaries in at least two respects. First, for the procedures we are proposing to add to the ASC list in CY 2007, the beneficiary copayment amount would be lower when these procedures are performed in an ASC than if they were performed in a hospital outpatient department. The difference in copayment amounts is attributable to the difference in the coinsurance rate between the ASC payment system and the OPPS. That is, the coinsurance rate for all surgical procedures payable under the ASC benefit is 20 percent of the standard overhead amount, whereas the coinsurance rate for the same surgical procedures performed in a hospital outpatient setting ranges from 20 percent to 40 percent under the OPPS. In addition, in accordance with section 5103 of Pub. L. 109–171, no ASC payment rate in CY 2007 may be greater than the OPPS rate for a given procedure. Thus, due to the limitations on the ASC facility rate required by Pub. L. 109–171, beneficiaries will be assured a lower ASC copayment amount for procedures in CY 2007 than in previous years. The only exceptions would be when the ASC copayment amount exceeds the inpatient deductible. The statute requires that copayment amounts under the OPPS not exceed the inpatient deductible.

Second, beneficiary access to services would be expanded by the proposed addition of 14 surgical procedures to the ASC list. Beneficiaries would have an additional setting from which to choose were it necessary for them to undergo one of the surgical procedures that we are proposing to add the ASC list in CY 2007.

5. Conclusion

The impact on ASCs of proposed changes to the ASC payment system for CY 2007 would depend on an individual ASC's mix of patients and its payers, specifically, the proportion of its patients who are Medicare beneficiaries, whether or not the ASC chooses to perform the procedures proposed for addition to the ASC list, and whether or not the ASC provides services that will be affected by the payment limits imposed by section 5103 of Pub. L. 109–171. Overall, the Office of the Actuary estimates that the Medicare program would realize a $35 million savings as a result of implementing the changes proposed for CY 2007.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table 51 below, we have prepared an accounting statement showing the classification of the expenditures associated with the CY 2007 ASC provisions of this proposed rule. This table provides our best estimate of the reduction in Medicare payments under the ASC payment system as a result of the changes presented in this proposed rule for CY 2007. All expenditures are classified as transfers to Medicare providers (that is, ASC).

TABLE 51.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED ASC EXPENDITURES FROM CY 2006 TO CY 2007

Category	Transfers
Annualized Monetized Transfers	$150 million savings.
From Whom to Whom	Medicare ASC Suppliers to the Federal Government.
Annualized Monetized Transfer	$50 Million Impact.
From Whom to Whom	Decrease in Premium from Beneficiaries to Federal Government.
Total	$100 million savings.

D. Effects of Proposed Revisions to the ASC Payment System for CY 2008

(If you choose to comment on issues in this section, please include the caption ''CY 2008 ASC Impact'' at the beginning of your comment.)

In CY 2008, we are proposing to implement a completely revised Medicare ASC payment system that could have a far-reaching effect on the provision of outpatient surgical services for a number of years to come. First, we are proposing to greatly expand the list of procedures that would be eligible for payment of an ASC facility fee. Second, we also are proposing to move from a limited fee schedule based on nine disparate payment groups to a payment system incorporating relative payment weights and APC groups, which are key elements of the hospital OPPS.

Implementation by January 1, 2008 of a revised ASC payment system designed to result in budget neutrality is mandated by section 626 of Pub. L. 108–173. To set ASC payment rates for CY 2008 under the revised system, we are proposing to multiply ASC relative payment weights for surgical procedures by an ASC conversion factor that we would calculate to result in the same aggregate expenditures for ASC services

in CY 2008 that we estimate would have been made if the revised payment system were not implemented.

The effects of the expanded ASC list combined with significant changes in payment rates for ASC facility services would vary across ASCs, depending on whether or not the ASC limits its services to those in a particular surgical specialty area, the volume of specific services provided by the ASC, and the percentage of its patients that are Medicare beneficiaries.

The Office of the Actuary estimates that the revised payment system proposed in section XVIII. of this preamble would result in neither savings nor costs for the Medicare program. That is, because it is designed to be budget neutral, the revised ASC payment system proposed for implementation in CY 2008 would neither increase nor decrease expenditures under Part B of Medicare. The Office of the Actuary further estimates that beneficiaries would save approximately $30 million under the revised ASC payment system proposed for implementation in CY 2008 because ASC payment rates would in all cases be lower than OPPS payment rates for the same services, and because beneficiary coinsurance for ASC services is a strict 20 percent rather than the 20–40 percent coinsurance rates allowed under the OPPS. (The only exceptions would be when the copayment amount for a procedure under the revised ASC payment system exceeds the hospital inpatient deductible. Section 1833(t)(8)(C)(i) of the Act provides that the copayment amount for a procedure paid under the OPPS cannot exceed the inpatient deductible established for the year in which the procedure is performed.)

1. Alternatives Considered

We are issuing this proposal to meet a statutory requirement to implement, no later than January 1, 2008, a revised payment system for ASCs. We are proposing to implement the revised payment system and expanded list through rulemaking in the **Federal Register** to afford interested parties an opportunity to comment on revisions we are proposing to the policies and rules for identifying surgical procedures that would be approved for payment of an ASC facility fee and the revisions we are proposing to the ASC ratesetting methodology and payment policies and regulations under the revised ASC payment system.

Throughout section XVIII. of this preamble, we discuss the various options we considered as we developed proposals to redesign the ASC payment system in broad terms, and specific policies, such as those affecting payment for ancillary services related to surgical procedures, the definition of a surgical procedure, criteria for identifying procedures that are not safely or appropriately performed in an ASC, and so forth.

Although we propose in section XVIII. of this preamble to phase in the new ASC payment rates under the revised payment system over a 2-year period, we initially considered fully implementing the new rates for ASC services furnished on or after January 1, 2008. However, as we discuss below, our analysis of the effect that the change in payments might have on ASCs led us to propose implementation of payment rates in CY 2008 that would be based upon a 50/50 blend of the estimated current payment rate with the new payment rate. We believe that allowing a blended rate in the first year is appropriate in light of the adverse financial impact that some ASCs could potentially experience if they perform a high volume of procedures whose rates would significantly decrease under the revised system. We want to emphasize that our proposed blended payment is but one of the numerous provisions we propose in section XVIII. of this preamble as comprising the revised ASC payment system. That is, our proposal to make payment for a surgical procedure in the first year we implement the revised payment system of only 50 percent of the payment rate determined in accordance with the current payment system, would be built into and considered integral to full implementation of the revised ASC payment system proposed for CY 2008.

2. Limitations of Our Analysis

Without datasets related to classes of ASCs which parallel the data maintained in the Medicare provider-specific files for hospitals, we cannot model distributional impacts of the proposed CY 2007 changes in the ASC list and ASC payments similar to those that we prepare in our impact analysis for the OPPS (see Table 49 in section XXVII.B. above). The impacts presented here are the projected effects of the policy and statutory changes that would be effective for CY 2008, on aggregate ASC utilization and Medicare payments. We can only infer the effects of the revised payment system on different types of ASCs, for example, single or multispecialty, high or low volume, urban or nonurban ASCs, based on an overall comparison of procedure volume and facility payments between the current and the proposed payment system. Moreover, because ASCs are not required to file Medicare cost reports, we do not have those as a source of data to help evaluate whether or not the payments for ASC services are appropriate, taking into account the resources required by ASCs to perform different surgical procedures.

Because the aggregated impact tables below are based upon a methodology that assumes no changes in service mix or volumes with respect to the most recent CY 2005 ASC data, our estimates of the percent change in allowed charges based on the revised payment system for CY 2008 are necessarily limited. We believe it is likely that the volumes and service mix of procedures provided in ASCs would change significantly in CY 2008 under the revised payment system, although we are unable to accurately project these changes. At this point, our data do not enable us to confidently estimate the net potential for migration of services among ambulatory care settings that might result from implementation of the proposed revised ASC payment system. As we have done in previous proposed rules, we rely on comments and information from stakeholders to mitigate the limitations in the data available to us for analysis of the impact these proposed changes would have on individual ASCs, on classes of specialty ASCs, on hospitals, on physicians and on beneficiaries.

3. Estimated Effect of This Proposed Rule on ASCs

Some ASCs are multispecialty facilities that perform the gamut of surgical procedures from excision of lesions to hernia repair to cataract extraction; others focus on a single specialty and perform only a limited range of surgical procedures, such as eye procedures or gastrointestinal procedures or orthopedic surgery. The combined effect on an individual ASC of the proposed revised CY 2008 payment system and the proposed expanded list of procedures 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, and the percentage of its patients who are Medicare beneficiaries. An individual ASC's revenues from non-Medicare sources might or might not be affected by the Medicare payment changes depending on the mix of services it provides to its non-Medicare patients and the extent to which revenues from other payors are influenced by the Medicare payment rates.

To estimate changes in Medicare payments for current ASC services, we

compared estimated payment rates for CY 2008 under the current system with the estimated proposed payment rates for CY 2008 under the revised system. In analyzing these comparisons, we became concerned about the significant negative effect the new payment rates might have on Medicare revenues for certain surgical procedures that are frequently performed in ASCs. We also became concerned about the impact of the revised payment rates on ASCs that specialize in a limited number of surgical procedures for which payment would decrease under the new system. We do not want the revised payment system to cause procedures currently performed in high volume in ASCs to migrate to hospital outpatient departments in response to sudden payment reductions. On the contrary, we want to encourage procedures that are being frequently performed in ASCs at the present time to continue being performed in ASCs because, in all likelihood, the ASC has become an extremely efficient setting for high volume procedures, such as cataract extraction and colonoscopies. Moreover, we believe one of the positive outcomes of the revised ASC payment system could be to expand beneficiary and physician choice when it comes to selecting an appropriate site for ambulatory surgical services as a consequence of the expansion of surgical services available in the ASC setting and revised payment rates that pay more appropriately for ASC facility services. Therefore, to give ASCs additional time to reconfigure their case mix so that they can focus on achieving more efficient delivery of a broader range of services, we are proposing during the first year of the revised payment system (CY 2008) to pay ASCs using a blended rate, 50 percent of the CY 2007 ASC rate for surgical procedures on the CY 2007 ASC list added to 50 percent of the CY 2008 proposed ASC rate.

Table 52 shows the impact at the APC group level, sorted by APC group, of the revised payment system if we were to apply a 50/50 blend of the old ASC payment rate and the new ASC payment within the particular APC group. The APC groups shown in this table are those for which we estimate CY 2008 allowed charges under the revised payment system would exceed $5 million. Procedures assigned to these APCs account for the highest aggregate allowed charges under the current payment system. The following is an explanation of the information represented in Table 52:

- Column 1—*APC Group* indicates the APC classification of procedures to which the ASC expenditures are attributed. For a listing of the individual HCPCS codes assigned to the APC groups, see Addendum C of this proposed rule, which can be found on the CMS Web site.
- Column 2—*Allowed Charges* are the Medicare payment amounts for covered ASC surgical procedures. Allowed charges include both Medicare program payments and coinsurance and deductibles, which are the financial responsibility of the beneficiary. These amounts have been summed across all procedures provided within the particular APC by ASCs. The allowed charges are expressed in millions of dollars.
- Column 3—*CY 2008 Percent Change* (under 50/50 Blend): The CY 2008 impact of the revised ASC payment system under the transition is the percentage increase or decrease in allowed charges attributable to changes in the ASC payment rates for CY 2008 under a 50/50 blend of the old ASC payment rate and the new ASC payment within the particular APC group.

TABLE 52.—ESTIMATED CY 2008 IMPACT OF THE PROPOSED REVISED ASC PAYMENT SYSTEM ON AGGREGATE ALLOWED CHARGES UNDER THE 50/50 BLEND, BY APC GROUP

APC group	Allowed charges (in millions)	CY 2008 percent change (under 50/50 Blend)
0021—Level III Excision/ Biopsy	$7	20
0022—Level IV Excision/ Biopsy	12	34
0027—Level IV Skin Repair	6	33
0028—Level I Breast Surgery	7	25
0041—Level I Arthroscopy	56	35
0042—Level II Arthroscopy	14	108
0051—Level III Musculoskeletal Procedures Except Hand and Foot	17	55
0053—Level I Hand Musculoskeletal Procedures	20	17
0054—Level II Hand Musculoskeletal Procedures	6	39
0055—Level I Foot Musculoskeletal Procedures	36	28
0057—Bunion Procedures	9	60
0075—Level V Endoscopy Upper Airway	14	27
0140—Esophageal Dilation without Endoscopy	10	−18
0141—Level I Upper GI Procedures	233	−12
0143—Lower GI Endoscopy	427	−11
0154—Hernia/Hydrocele Procedures	15	31
0158—Colorectal Cancer Screening: Colonoscopy	63	−15
0160—Level I Cystourethroscopy and other Genitourinary Procedures	26	−11
0161—Level II Cystourethroscopy and other Genitourinary Procedures	14	35
0162—Level III Cystourethroscopy and other Genitourinary Procedures	11	51
0163—Level IV Cystourethroscopy and other Genitourinary Procedures	5	20
0184—Prostate Biopsy	8	−18
0203—Level IV Nerve Injections	9	25
0206—Level II Nerve Injections	58	−17
0207—Level III Nerve Injections	209	−12
0220—Level I Nerve Procedures	22	30
0233—Level II Anterior Segment Eye Procedures	8	17
0234—Level III Anterior Segment Eye Procedures	17	23
0240—Level III Repair and Plastic Eye Procedures	47	7
0244—Corneal Transplant	7	27

TABLE 52.—ESTIMATED CY 2008 IMPACT OF THE PROPOSED REVISED ASC PAYMENT SYSTEM ON AGGREGATE ALLOWED CHARGES UNDER THE 50/50 BLEND, BY APC GROUP—Continued

APC group	Allowed charges (in millions)	CY 2008 percent change (under 50/50 Blend)
0246—Cataract Procedures with IOL Insert	1,100	−2
0247—Laser Eye Procedures Except Retinal	97	−18
0254—Level IV ENT Procedures	6	31
0672—Level IV Posterior Segment Eye Procedures	23	41
0686—Level III Skin Repair	54	−5
All Other (APC categories less than $5 million)	110	25
Total	2,785	0

Table 53 below shows the impact of the revised payment system on total payments for selected high volume procedures during the first year the revised payment system is implemented (CY 2008). These are the most frequently performed procedures at ASCs under the current Medicare payment system. The HCPCS codes are sorted in descending order by estimated allowed charges. The percent change in this table again compares payment rates for CY 2008 under the current system with our estimate of the proposed payment rates for CY 2008, incorporating a 50/50 blend of the ASC payment under the current system and the ASC payment under the revised system.

TABLE 53.—ESTIMATED CY 2008 IMPACT OF REVISED ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR SELECTED HIGH VOLUME PROCEDURES UNDER THE 50/50 BLEND

HCPCS Code	Description	Allowed charges (in millions)	CY 2008 percent change (50/50 Blend)
66984	Cataract surg w/iol, 1 stage	$1,062	−2
43239	Upper gi endoscopy, biopsy	166	−13
45378	Diagnostic colonoscopy	147	−11
45380	Colonoscopy and biopsy	112	−11
45385	Lesion removal colonoscopy	108	−11
66821	After cataract laser surgery	97	−18
62311	Inject spine l/s (cd)	78	−12
45384	Lesion remove colonoscopy	45	−11
64483	Inj foramen epidural l/s	42	−12
64476	Inj paravertebral l/s add-on	39	−17
G0121	Colon ca scrn; not high rsk	37	−15
66982	Cataract surgery, complex	32	−2
15823	Revision of upper eyelid	29	−13
43235	Uppr gi endoscopy, diagnosis	28	−1
G0105	Colorectal scrn; hi risk ind	26	−15
64475	Inj paravertebral l/s	25	−12
52000	Cystoscopy	24	−10
64484	Inj foramen epidural add-on	20	−12
67904	Repair eyelid defect	18	4
43248	Uppr gi endoscopy/guide wire	18	−13
64721	Carpal tunnel surgery	17	30
29881	Knee arthroscopy/surgery	17	41
28285	Repair of hammertoe	15	29
64623	Destr paravertebral n add-on	15	−12
62310	Inject spine c/t	13	−12
29880	Knee arthroscopy/surgery	12	41
26055	Incise finger tendon sheath	11	22

Over time, we believe the current ASC payment system has served as an incentive to ASCs to focus on providing procedures for which they determine Medicare payments are adequate to support the ASC's continued operation. In our analyses of the effects of the new payment rates, we found that the ASC payment rates for many of the procedures performed most frequently in ASCs are equal to or greater than the OPPS rates for the same procedures. Conversely, procedures for which the current ASC payment rates are lower than the OPPS rates for the same procedures tend to be performed less frequently in ASCs. We believe the proposed revised payment system represents a major stride towards encouraging greater efficiency in ASCs and promoting a significant increase in the scope and breadth of surgical procedures performed in ASCs because it would more appropriately distribute

payments across the entire spectrum of surgical procedures, based on a coherent system of relative payment weights. As a consequence, we expect that there would be changes in the mix of procedures provided in ASCs under the proposed revised payment system because the revised payment system would encourage ASCs to expand their service mix beyond the handful of the most lucrative procedures which comprise the bulk of ASC utilization under the current Medicare payment system.

There are also some procedures for which the current ASC and OPPS rates are roughly equivalent. Under the proposed revised payment system, those services would be paid a significantly lower amount than they are currently. We believe that in some cases the payment under the current ASC system is generous relative to ASC costs, so ASCs would in all likelihood continue performing those procedures under the proposed revised payment system. To the extent that ASCs determine that the new rates for specific services or types of procedures are inadequate relative to the costs of those services, we would expect a change in the mix of services the ASC provides.

Table 53 identifies a number of high volume procedures for which ASC payments would decrease under the revised system, although payments would increase significantly for other high volume procedures. What Table 53 does not show are the hundreds of other procedures currently on the ASC list that have very low volume, which we believe correlates with the low payment rates currently set for those procedures. Under the revised system, payment rates would increase significantly for numerous procedures that are currently underpaid when compared with payments for the same services under the OPPS. While an ASC may earn less from providing a service that has been its highest volume (and best paid) procedure under the current system because the payment rate for that procedure is lower under the revised payment system, that ASC may more than offset the reduction in revenues by beginning to perform other services for which the proposed rates under the revised system are significantly higher. The procedures displayed in Table 53 (current high volume procedures) are the highest volume procedures under the current system but we expect that other procedures will become high volume procedures under the revised system.

While Table 52 suggests that payment for some types of procedures would decrease and others would increase, considering multiple procedures as a clinically related group generally moderates some of the extreme increases and decreases in payments displayed in Table 53 for selected high volume procedures that are members of those groups. ASCs with particular capabilities for specializing in urological or gastrointestinal procedures could shift their focus to other related procedures in the same taxonomy whose payment rates were more favorable. Those specialty ASCs could potentially continue to draw upon their experiences and resources to perform other related services.

The tables above show how payment for high volume procedures currently on the ASC list would be affected by changes in payment using the ASC relative payment weights and rate setting methodology proposed under the new payment system. We also propose to add in CY 2008 hundreds of surgical procedures to the already extensive list of services for which Medicare allows payment of an ASC facility fee, creating new opportunities for ASCs to expand their range of Medicare-approved surgical procedures. Table 54 suggests some of the potential for growth that ASCs could realize under the revised payment system. The codes in this table are selected high volume procedures currently performed predominantly in the office and/or hospital outpatient setting. We believe the payment rates for these procedures under the proposed revised system would make them attractive additions to the existing surgical choices that ASCs currently offer Medicare beneficiaries in the areas of gastroenterology, urology, and pain management. Note that we have included columns to show the MPFS nonfacility rate, office volume, and a column entitled ''OPPS Rate Adjusted to CY 2008 ASC Rate'' that shows the proposed blended CY 2008 payment rate for each procedures that is compared to the MPFS nonfacility rate to determine which is the proposed CY 2008 rate. The procedures that are on the office-based list and, are therefore, subject to payment limitation (the lesser of the ASC rate or the MPFS nonfacility rate) are denoted with an asterisk. We have also denoted with an asterisk, those proposed CY 2008 ASC payments that are limited by the nonfacility rate.

TABLE 54.—SELECTED HIGH VOLUME PROCEDURES PROPOSED FOR ASC PAYMENT FOR CY 2008

CPT code	Short descriptor	Proposed CY 2007 OPPS payment rate	Proposed CY 2008 MPFS nonfacilty rate	Proposed CY 2008 ASC payment rate	OPPS or physician office volume	Payment for office-based procedure if no payment cap
45300*	Proctosigmoidoscopy dx	$295.48	$60.03	$60.03	39524	$183.19
45330*	Diagnostic sigmoidoscopy	295.48	81.86	81.86	42684	183.19
46600*	Diagnostic anoscopy	38.23	51.50	23.70	80577	23.70
46934	Destruction of hemorrhoids	792.64	177.36	177.36	34423	491.43
47562	Laparoscopic cholecystectomy	2,678.23	N/A	1,660.48	30,029	1,660.48
47563	Laparo cholecystectomy/graph	2,678.23	N/A	1,660.48	13,979	1,660.48
50590	Fragmenting of kidney stone	2,734.57	N/A	1,683.45	26,549.00	1,683.45
53850*	Prostatic microwave thermotx	2,604.69	2,459.51	1,653.04	31796	1,653.04
53852*	Prostatic rf thermotx	2,604.69	2,320.01	1,653.04	8574	1,653.04
61795	Brain surgery using computer	338.56	N/A	209.90	1,067	209.90
62368*	Analyze spine infusion pump	173.90	21.83	21.83	122336	107.82
64450*	N block, other peripheral	138.43	42.29	42.29	132194	85.83
64612*	Destroy nerve, face muscle	138.43	68.90	68.90	35679	85.83
64640*	Injection treatment of nerve	341.23	189.09	189.09	79126	211.56

Unlike hospital outpatient departments, ASCs typically provide only a select set of procedures, and those procedures are generally performed on a scheduled, elective basis, affording ASCs much greater control over their case mix and costs than is possible for a typical hospital outpatient department. We expect that, as a result of implementation of the changes proposed under the revised ASC payment system, some procedures for which payment would decrease could migrate to other ambulatory settings. Conversely, we expect ASC volume to increase for those procedures for which payment rates go up under the revised payment system. These decisions will be made at the individual ASC level, depending on its physician staff, types of patients and its payors, and other considerations.

4. Estimated Effects of This Proposed Rule on Beneficiaries

We estimate that the proposed changes for CY 2008 would be positive for beneficiaries in at least two respects. The ASC coinsurance rate is set at 20 percent rather than between 20 percent and 40 percent as is the case under the OPPS. Because ASC payment rates under the revised payment system are lower than payment rates for the same procedures under the OPPS, the beneficiary copayment amount under the ASC payment system would generally be less than the OPPS copayment amount for like services. (The only exceptions would be when the ASC copayment amount exceeds the inpatient deductible. The statute requires that copayment amounts under the OPPS not exceed the inpatient deductible.)

In addition to the potential for reduced copayments, beneficiary access to services could be expanded as a result of the addition of the proposed 763 surgical procedures to the ASC list of services eligible for Medicare payment. We expect that ASCs would provide a broader range of surgical services under the revised system and that beneficiaries would benefit from having access to a greater variety of surgical procedures in ASCs.

5. Conclusion

The proposed changes to the ASC payment system for CY 2008 would affect each of the more than 4,000 ASCs currently approved for participation in the Medicare program. The effect on an individual ASC will depend on the ASC's mix of patients, the proportion of their patients that are Medicare beneficiaries, the degree to which the payments for the procedures offered by the ASC are changed under the proposed revised system, and the degree to which the ASC chooses to provide a different set of procedures. The revised payment system is designed to result in the same aggregate amount of expenditures that would be made under the ASC benefit if the revised system were not implemented. The budget neutrality of the new payment system would not be affected by the proposed two year transition to full implementation of the new payment rates.

E. Effects of the Medicare Contracting Reform Mandate

(If you choose to comment on issues in this section, please include the caption ''Medicare Contracting Reform Impact'' at the beginning of your comment.)

In section XIX. of this preamble, we discuss our proposal to revise the regulations under 42 CFR Part 421, Subpart B for Medicare intermediaries and carriers to conform the regulations to the statutory changes mandated by section 1874A of the Act as added by section 911 of Pub. L. 108–173, which took effect on October 1, 2005. As discussed in section XIX. of this preamble, section 1874A of the Act is intended to improve Medicare's administrative services to beneficiaries and health care providers and to bring standard contracting principles to Medicare, such as competition and performance incentives, which the government has long applied to other Federal programs under the FAR. This provision requires that CMS replace its current claims payment contractors by October 1, 2011 with new contract entities referred to as MACs. We believe that this provision has no immediate economic effect on Medicare payments in CY 2007 because it is administrative in nature and does not change Medicare's coverage and reimbursement policies for hospital outpatient services or any other covered Medicare services.

F. Effects of Proposed Additional Quality Measures and Procedures for Hospital Reporting of Quality Data for IPPS FY 2008

We have tried to minimize the costs of HCAHPS®, including minimizing the impact on small/rural hospitals. While there are no capital or operational/maintenance costs associated with the implementation of HCAHPS®, there are costs for collecting the data. The nationwide cost of conducting the HCAHPS® survey are estimated to be between $3.6 million and $16.9 million per year assuming approximately 3,700 hospitals (see Abt Associates, Inc. report, *http://www.cms.hhs.gov/HospitalQualityInits/downloads/HCAHPS®CostsBenefits200512.pdf*).

We have reduced the burden for small/rural hospitals by making it possible to conduct the HCAHPS® survey without hiring a survey vendor; we have provided a free online data entry tool to simplify submission for reporting; we have required significantly fewer completed surveys of small hospitals than of larger hospitals; and we have permitted four different modes of survey administration, which will allow hospitals to administer the survey in the manner most familiar to them.

In addition, hospitals that are self-administering the survey (or their survey vendor, if the hospital chooses to employ one) beginning in 2007 will participate in free HCAHPS® training offered via Webinar in January 2007. All hospitals that join in 2007 will be required to participate in a month-long dry run in March 2007. Hospitals that chose not to participate in HCAHPS® will not meet the HCAHPS® requirements necessary to receive the full market basket update for FY 2008.

The costs of collecting HCAHPS® patient survey data will vary across hospitals depending on the method used to collect patient survey data, the number of patients surveyed, and whether HCAHPS® is incorporated into their existing patient satisfaction surveys. While hospitals may choose to administer HCAHPS® as a stand-alone survey, there are significant cost savings associated with combining HCAHPS® with existing surveys. Hospitals will have a financial incentive to administer a single survey that includes both HCAHPS® and information necessary to support quality improvement activities.

We have cited a cost/benefit report showing that the costs of conducting HCAHPS® would be as follows. HCAHPS® collected as a separate survey is between $11.00 and $15.25 per complete survey ($3,300 to $4,575 per hospital), assuming that 80–85 percent of hospitals collect HCAHPS® by mail and the remainder by phone or active IVR. It would be considerably less expensive to combine HCAHPS® with existing surveys. In a combined survey, it is estimated that it would cost only $3.26 per complete survey (or $978 per hospital) to incorporate the 27-item HCAHPS® instrument into existing surveys. Depending on the proportion of hospitals that incorporate HCAHPS® into existing surveys, it is therefore estimated that the costs of HCAHPS® is between $3.6 million and $16.9 million per year (Abt Associates, Inc. report, *http://www.cms.hhs.gov/*

HospitalQualityInits/downloads/HCAHPS®CostsBenefits200512.pdf).

We have made provisions to reduce the burden of the HCAHPS® initiative for small/rural hospitals. As a cost savings provisions for all hospitals (but one that is particularly useful for small hospitals), a free on-line tool for data entry is available to hospitals choosing to conduct data entry themselves in lieu of contracting with a survey vendor for this service. The sample size requirements are reduced for small hospitals unable to achieve 300 completed surveys. For all hospitals, we are allowing four modes of survey administration (mail, telephone, combination of mail and telephone, and active interactive voice recognition), and we are allowing for hospitals to either use a vendor or conduct the survey on their own. Additionally, we are allowing hospitals to integrate the HCAHPS® survey with their own patient satisfaction surveys. This option provides significant cost savings to conduct HCAHPS® annually: for the mail mode, it is estimated to cost $603 per hospital; and for the telephone mode, it is estimated to be $2,478 per hospital. For hospitals collecting 100 completed surveys, it costs about $326 annually per hospital. CMS is providing free HCAHPS® training and materials and the cost of reporting HCAHPS® results to CMS is minimal.

The benefits of public reporting for hospitals are great. There are multiple reports of hospitals being motivated by these data and using them for improvement. Not only is there more consistent evidence regarding hospital impact, but there are also several well-designed studies that have found at least some impact on hospital clinical performance (Abt report).

HCAHPS® provides many benefits to hospitals and also to society at-large. The HCAHPS® initiative has taken substantial steps to assure that the survey will be credible, useful, and practical. First, the survey is designed to produce comparable data on the patient's perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care. Third, public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for the public investment. For the public at-large, there is the potential benefit of improved health through improvements in hospital care.

The intent of having the HCAHPS® initiative that resulted in a unique hospital survey is to provide one standardized instrument and accompanying data collection methodology that is in the public domain for measuring patients' perspectives on hospital care. While many hospitals currently collect information on patients' satisfaction with care, there is no one national standard for collecting or publicly reporting this information that would enable valid comparisons to be made across all hospitals. In order to make ''apples to apples'' comparisons to support consumer choice, it is necessary to introduce a standard measurement approach. HCAHPS® can be viewed as a core set of questions that can be combined with a broader, customized set of hospital-specific items. HCAHPS® is meant to complement the data hospitals currently collect to support improvements in internal customer services and quality related activities.

• SCIP

While there are no capital or operational/maintenance costs associated with the implementation of SCIP, our pilot study concluded that there will be costs associated with the collection of the data. The data collection costs have been calculated as follows: SCIP collection as additional measures has been calculated to be $75.00 and $100.00 per additional hour of data abstraction (approximately $16,000 per hospital). Depending on the proportion of hospitals that already collect these measures, it is estimated that the costs of collecting the additional measures is approximately $58.7 million dollars per year. For a detailed discussion of the data collection burden (burden hours) associated with these costs, please refer to the information collection section of the preamble.

• Mortality

The 30-day mortality measures for AMI, HF and Pneumonia are each individually calculated solely on administrative data already submitted to CMS for other purposes, such as claims submitted for payment by the hospitals. As no new or additional data will be required from hospitals to calculate the rates for these measures, we believe that there will be no measurable impact on the hospitals as a result of the inclusion of any or all of these measures in the RHQDAPU set.

1. Alternatives Considered

The HCAHPS® survey and the SCIP and mortality measures are a subset of CMS's larger Quality Initiative for both the Medicare and Medicaid programs. The Hospital Quality Initiative was established nationally in November 2002 for nursing homes, and was expanded in 2003 to the nation's home health care agencies and hospitals. The Hospital Quality Initiative supports significant improvement in the quality of hospital care that is integral to both the Medicare and Medicaid programs. This initiative aims to improve hospital's quality of care by distributing objective and easy to understand data on hospital performance. The public availability of this information will encourage consumers and their physicians to discuss and make better informed decisions on how to get the best hospital care, create incentives for hospitals to improve care, and support public accountability. In all, improved care equates to the improvement of health for Medicare and Medicaid beneficiaries.

HCAHPS®, SCIP and Mortality measures parallel the trend in both the federal and many state governments to make hospital performance information (generally clinical processes or outcomes of care) publicly available. The goals of HCAHPS® are to (1) Produce comparable data on the patient's perspective on care to allow objective and meaningful comparisons between hospitals on domains that are important to consumer decision-making, (2) to have these data publicly reported to create incentives for hospitals to improve their quality of care, and (3) to enhance public accountability by providers by increasing the transparency of the quality of hospital care provided in return for the public investment. HCAHPS®, SCIP and Mortality measures fit into a larger context of performance reporting developed by the Strategic Framework Board of the National Quality Forum. This is based on the assumption that consumers take value (both cost and quality) into account in any major purchasing decision. Public reporting of both the clinical measures and HCAHPS® is vital to the value-based healthcare purchasing approach. Patient perspectives of care encompasses an important CMS priority, as indicated by the Agency's support for programs related to the Institute of Medicine's (IOM) call for public reporting, the Hospital Quality Initiative (HQI) and the Hospital Quality Alliance (HQA), a public-private measurement and reporting collaborative.

The HCAHPS® survey has been endorsed by the Hospital Quality Alliance. Implementing this survey fulfills the requirements

1886(b)(3)(B)(viii)(III) and (IV) of the Act that require CMS to expand the starter set of 10 quality measures used since FY 2005. In expanding these measures, we must begin to adopt the baseline set of performance measures as set forth in a 2005 report issued by the Institute of Medicine (IOM) of the National Academy of Sciences under section 238(b) of Pub. L. 108–173, effective for payments beginning with FY 2007. The IOM measures include the Hospital Quality Alliance (HQA) measures, the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) patient perspective survey, and three structural measures.

No alternatives were discussed for the SCIP and mortality measures.

2. Estimated Effects of This Proposed Rule

a. Effects on Hospitals

Hospitals will benefit from the information that the HCAHPS® survey and the SCIP and Mortality measures data collection will provide. Hospitals are an essential part of the National Quality Forum's Strategic Framework Board. We have made provisions that reduce the burden of the HCAHPS® initiative, especially for small/rural hospitals. The public reporting of HCAHPS® results and additional quality measures may stimulate improvements in hospital quality of care in several ways. Hospitals can use the publicly reported data to benchmark their performance with other institutions. Consumers/patients would potentially seek care in hospitals that are publicly reported to perform well.

CMS does not plan to make major revisions to the HCAHPS® survey itself or to its implementation procedures soon after HCAHPS® national implementation. With the core set of HCAHPS® measures, hospitals will have the beginnings of a benchmark for trending of their hospital results over time.

To promote its wide and rapid adoption, HCAHPS® has been carefully designed to fit within the framework of patient satisfaction surveying that hospitals currently employ. Still, CMS fully understands that participation in the HCAHPS® initiative will require some effort and expense on the part of hospitals that volunteer to take part.

b. Effects on Other Providers

Physicians will benefit by learning what surveyed consumers/patients answered about their quality of care during their hospital stays, as well as become informed about surgical care improvement and mortality rates. Studies indicate that providers are potentially affected by public reporting. They may be motivated to improve the quality of care they deliver with the availability of performance information. Primary care physicians are also users of this information during the referral process of patients to hospitals. Studies indicate that the public reporting of hospital quality indicators may spur internal hospital quality improvement and lead to changes in physician behavior within the hospital environment.

c. Effects on the Medicare and Medicaid Programs

Some potential benefits of publicly reporting quality information has been described in the literature as pertaining to consumers, providers and purchasers. Consumers (beneficiaries) could incorporate the quality information into their decision-making about hospital choices, and benefit from better care resulting from the additional measures as well as the questions asked by HCAHPS®, such as questions about communication with providers (fewer medical errors due to patient feedback about medication effect) and discharge planning (fewer readmissions due to better patient awareness about what to expect when discharged) and the reporting of clinical measures.

Providers could potentially be motivated to improve the quality of care they provide for results of more effective and efficient hospital operation. Providers could also use the information internally to improve communication and improve performance, use the information to justify the need to increase staff ratios, use the measures in choices about practitioner practice locales, use the information to improve their ratings on patient perspectives and potentially compete with one another in the area of improving accreditation results, and use the information to choose hospitals on the basis of quality of care for their patients.

Purchasers could potentially benefit from this information for supporting shorter lengths of stay, availability of benchmarks, and availability of information to support purchasing decisions.

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 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 416

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 421

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant program-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 488

Administrative practice and procedure, Health facilities, Medicare, Reporting and recordkeeping requirements.

For reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR Chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 410.152 is amended by revising paragraph (i) to read as follows:

§ 410.152 Amounts of payment.

* * * * *

(i) *Amount of Payment: ASC facility services.* (1) For ASC facility services furnished on or after July 1, 1987 and before January 1, 2008, in connection with the surgical procedures specified in part 416 of this chapter, Medicare Part B pays 80 percent of a standard overhead amount as specified in § 416.120(c) of this chapter.

(2) For ASC facility services furnished on or after January 1, 2008, in connection with the surgical procedures specified in part 416 of this chapter, Medicare Part B pays the lesser of 80 percent of the actual charge, 80 percent of the prospective payment amount as

determined under Subpart F of Part 416 of this chapter, or, under the limitation described in § 416.167(b)(3), the amount determined under Subpart B of Part 414 of this chapter.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

3. The authority citation for Part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1834(l) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395m(l)).

4. Section 414.22 is amended by revising paragraph (b)(5)(i)(B) to read as follows:

§ 414.22 Relative Value Units (RVUs).

* * * * *

(b) *Practice Expense RVUs.*

* * * * *

(5) * * *

(i) * * *

(B) *Non-facility practice expense RVUs.* The higher non-facility practice expense RVUs apply to services performed in a physician's office, a patient's home, an ASC if the physician is performing a procedure for which an ASC facility fee is not paid under Part 416, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC performing an ASC approved procedure.

* * * * *

PART 416—AMBULATORY SURGICAL SERVICES

5. 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).

6. Section 416.1 is amended by—

a. Revising paragraph (a)(2).

b. Revising paragraph (a)(3).

c. Adding new paragraphs (a)(4) and (a)(5).

The revisions and additions read as follows:

§ 416.1 Basis and scope.

(a) * * *

(2) Section 1833(i)(1)(A) of the Act requires the Secretary to specify the surgical procedures that can be performed safely on an ambulatory basis in an ambulatory surgical center.

(3) Sections 1833(i)(2)(A) and (D), and 1833(a)(1)(G) of the Act specify the amounts to be paid for facility services furnished in connection with the specified surgical procedures when they are performed in an ASC.

(4) Section 1833(i)(2)(C) of the Act provides that if the Secretary has not updated amounts for ASC facility services furnished during a fiscal year through 2005 or a calendar year beginning with 2006, the amounts shall be increased by the percentage increase in the Consumer Price Index for all urban consumers as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved, except that, in fiscal year 2005, the last quarter of calendar year 2005, and each of the calendar years 2006 through 2009, the increase shall be zero percent.

(5) Section 1833(i)(2)(E) of the act provides that with respect to surgical procedures furnished on or after January 1, 2007, and before the effective date of the implementation of a revised payment system, the payment amount shall be the lesser of the ASC payment rate established under section 1833(i)(2)(A) of the act or the prospective payment rate for hospital outpatient department services established under section 1833(t)(3)(D). The lesser payment amount shall be determined prior to application of any geographic adjustment.

* * * * *

7. Section 416.2 is amended by—

a. Republishing the introductory test preceding the definitions

b. Revising the definitions of ''Covered surgical procedures'' and ''Facility services.''

The republished introductory text preceding the definitions and revised definitions read as follows:

§ 416.2 Definitions.

As used in this part:

* * * * *

Covered surgical procedures means those surgical procedures that meet the criteria specified in §§ 416.65 or 416.166, as applicable, and are published in the **Federal Register**.

Facility services means services that are furnished in connection with covered surgical procedures performed in an ASC.

8. The heading for Subpart D is revised to read as follows:

Subpart D—Scope of Benefits for Services Furnished Before January 1, 2008

9. Section 416.65 is amended by—

a. Revising the introductory text.

b. Revising paragraph (a)(4).

The revisions read as follows:

§ 416.65 Covered surgical procedures.

Effective for services furnished before January 1, 2008, covered surgical procedures are those procedures that meet the standards described in paragraphs (a) and (b) of this section and are included in the list published in accordance with paragraph (c) of this section.

(a) * * *

(4) Are not otherwise excluded under § 411.15 of this chapter.

* * * * *

10. A new § 416.76 is added to read as follows:

§ 416.76 Applicability.

The provisions of this subpart apply to facility services furnished before January 1, 2008.

11. The heading for Subpart E is revised to read as follows:

Subpart E—Prospective Payment System For Facility Services Furnished Before January 1, 2008

§ 416.120 [Amended]

12. In paragraph (a) of § 416.120, the cross-reference ''Part 413'' is removed and the cross-reference ''Part 419'' added in its place.

13. A new § 416.121 is added to read as follows:

§ 416.121 Applicability.

The provisions of this subpart apply to facility services furnished before January 1, 2008.

14. Section 416.125 is amended by adding a new paragraph (c) to read as follows:

§ 416.125 ASC facility services payment rate.

* * * * *

(c) For services furnished on or after January 1, 2007, and before the effective date of implementation of a revised payment system, the ASC payment rate for a surgical procedure shall be the lesser of the ASC payment rate established under paragraph (a) of this section or the prospective payment rate for the procedure established under section 419.32. The lesser payment amount shall be determined prior to application of any geographic adjustment.

§ 416.150 [Removed]

15. Section 416.150 is removed.

Subpart F—[Redesignated as Subpart G]

16. Existing Subpart F is redesignated Subpart G

17. A new Subpart F is added to read as follows:

Subpart F—Coverage, Scope of ASC Facility Services, and Prospective Payment System For Facility Services Furnished On Or After January 1, 2008

Sec.
416.160 Basis and scope.
416.161 Applicability.
416.163 General rules.
416.164 Scope of ASC facility services.
416.166 Covered surgical procedures.
416.167 Basis of payment.
416.171 Calculation of prospective payment rates for ASC services.
416.172 Adjustments to national payment rates.
416.173 Publication of revised payment methodologies and payment rates.
416.178 Limitations on administrative and judicial review.

§ 416.160 Basis and scope.

(a) *Statutory basis.* (1) Section 1833(a)(1)(G) of the Act provides that, beginning with the implementation date of a revised payment system for ASC facility services furnished in connection with a surgical procedure pursuant to section 1833(i)(1)(A) of the Act, the amount paid shall be 80 percent of the lesser of the actual charge for such services or the amount determined by the Secretary under the revised payment system.

(2) Section 1833(i)(1)(A) of the Act requires the Secretary to specify the surgical procedures that can be performed safely on an ambulatory basis in an ASC.

(3) 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 were no requirement for a revised payment system. The revised payment system shall be implemented no earlier than January 1, 2006, and no later than January 1, 2008. There shall be no administrative or judicial review under section 1869 of the Act, section 1878 of the Act, or otherwise of the classification system, the relative weights, payment amounts, and the geographic adjustment factor, if any, of the revised payment system.

(b) *Scope.* This subpart sets forth—

(1) The scope of ASC facility services and the criteria for determining the procedures for which Medicare pays an ASC facility fee; and

(2) The methodologies by which Medicare determines payment amounts for ASC facility services.

§ 416.161 Applicability.

The provisions of this subpart apply to ASC facility services furnished on or after January 1, 2008.

§ 416.163 General rules.

(a) The services for which payment is made under this subpart are ASC facility services as specified in § 416.164(a) furnished to Medicare beneficiaries by a participating ASC in connection with covered surgical procedures as determined by the Secretary in accordance with § 416.166.

(b) Physician services, including surgical procedures and all preoperative and post-operative services that are performed by a physician, are paid in accordance with Part 414 of this chapter.

(c) Items and services as specified in § 416.164(b) for which payment may be made under other provisions of Part 410 of this chapter are not included in the payment amount for ASC facility services.

§ 416.164 Scope of ASC facility services.

(a) *Included services.* ASC facility services include, but are not limited to—

(1) Nursing, technician, and related services;

(2) Use of the facility where the surgical procedures are performed;

(3) Items and services directly related to the pre-operative preparation of patients upon their admission to the ASC for surgery, to the performance of a surgical procedure(s) and to the post-operative and post-anesthesia care of patients prior to their discharge from the ASC. This includes, but is not limited to: Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver; drugs and biologicals; medical and surgical supplies and equipment; surgical dressings; implanted prosthetic devices, accessories and supplies including intraocular lenses (IOLs); implanted DME, accessories and supplies; splints and casts and related devices; and imaging services or other diagnostic tests or interpretive services directly related to a surgical procedure;

(4) Administrative, recordkeeping and housekeeping items and services;

(5) Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

(6) Supervision of the services of an anesthetist by the operating surgeon.

(b) *Excluded services.* Facility services do not include costs incurred to procure corneal tissue or items and services for which payment may be made under other provisions of Parts 410 and 414 of this chapter, such as physicians' services; X-ray or diagnostic procedures (other than those directly related to performance of the surgical procedure); ambulance services; leg, arm, back and neck braces other than those that serve the function of a cast or splint; artificial limbs; non-implantable prosthetic devices and durable medical equipment. In addition, they do not include anesthetist services furnished on or after January 1, 1989.

§ 416.166 Covered surgical procedures.

(a) *Covered surgical procedures.* Effective for services furnished on or after January 1, 2008, covered surgical procedures are those procedures that meet the general standards described in paragraph (b) of this section (whether commonly furnished in an ASC or a physician's office) and are not excluded under paragraph (c) of this section.

(b) *General standards.* Subject to the exclusions in paragraph (c) of this section, covered surgical procedures are surgical procedures specified by the Secretary that would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC.

(c) *General exclusions.* Notwithstanding paragraph (b) of this section, covered surgical procedures do not include those surgical and other medical procedures that—

(1) Generally result in extensive blood loss;

(2) Require major or prolonged invasion of body cavities;

(3) Directly involve major blood vessels;

(4) Are generally emergent or life-threatening in nature;

(5) Standard medical practice dictates that the beneficiary will typically be expected to require active medical monitoring and care at midnight following the procedure; or,

(6) Are otherwise excluded under § 411.15 of this chapter.

§ 416.167 Basis of payment.

(a) *Unit of payment.* Under the ASC prospective payment system, prospectively determined amounts are paid for facility services furnished to Medicare beneficiaries in connection with designated surgical procedures. Surgical procedures are identified by codes established under the Centers for Medicare & Medicaid Services Common Procedure Coding System (HCPCS). The prospective payment rate for each procedure for which payment is allowed under the ASC payment system is determined according to the methodology described in § 416.171. The manner in which the Medicare

payment amount and the beneficiary copayment amount for each procedure are determined is described in § 416.172.

(b) *Ambulatory payment classification (APC) groups and payment weights*

(1) ASC covered surgical procedures are classified using the APC groups described in § 419.31 of this chapter. An APC group consists of outpatient services and procedures that are comparable clinically and in terms of resources.

(2) For purposes of calculating ASC national payment rates under the methodology described in § 416.171, except as specified in paragraph (b)(3), of this section, an ASC covered surgical procedure is assigned the applicable APC relative payment weight described in § 419.31 of this chapter.

(3) Notwithstanding paragraph (b)(2) of this section, the relative payment weights for procedures paid in accordance with § 416.171(e) are determined so that the national ASC payment rate does not exceed the MPFS nonfacility amount paid for such procedures under Subpart B of Part 414 of this chapter.

§ 416.171 Calculation of prospective payment rates for ASC services.

(a) *Conversion factor for calendar year 2008.* CMS calculates a conversion factor so that payment for ASC services furnished in 2008 would result in the same aggregate amount of expenditures as would be made if the provisions in Subpart F did not apply.

(b) *Conversion factor for calendar year 2009 and subsequent years.* The conversion factor for a calendar year is equal to the conversion factor calculated for the previous year adjusted as follows:

(1) For calendar year 2009, the increase shall equal zero percent.

(2) For calendar year 2010 and subsequent years, by the Consumer Price Index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(c) *Transitional payment rates for calendar year 2008.* ASC payment rates for 2008 are a transitional blend of 50 percent of the CY 2007 ASC payment rate for a surgical procedure on the CY 2007 ASC list of surgical procedures and 50 percent of the payment rate for the procedure calculated under the methodology described in paragraph (d) of this section.

(d) *Payment rates for calendar year 2009 and subsequent years.* The national ASC payment rate for a covered surgical procedure designated in accordance with § 416.166 is the product of the conversion factor calculated under paragraph (a) or paragraph (b) of this section and the relative weight determined under § 416.167(b).

(e) *Limitation on payment for certain ASC procedures.* Notwithstanding the provisions of paragraph (c) and paragraph (d) of this section, if CMS determines that a covered procedure under § 416.166 of this part is commonly performed in physicians' offices, payment for ASC facility services for such procedure shall be the lesser of the amount determined under paragraph (c) or paragraph (d) of this section or the amount paid for such procedure under Subpart B of Part 414 of this chapter.

(f) *Budget neutrality.* (1) For calendar year 2008, CMS adjusts the conversion factor in accordance with paragraph (a) to result in budget neutrality as estimated by CMS.

(2) For calendar year 2009 and subsequent years, CMS adjusts the ASC relative payment weights under § 416.167(b)(2) as needed so that any updates and adjustments made under § 419.50(a) of this chapter are budget neutral as estimated by CMS.

§ 416.172 Adjustments to national payment rates.

(a) *General rule.* CMS establishes national prospective payment rates for ASC facility services to which certain adjustments are applied to determine Medicare program payment and beneficiary copayment amounts.

(b) *Lesser of actual charge or prospective rate.* Payments to ASCs shall equal the lesser of 80 percent of:

(1) the actual charge for the service; or,

(2) the prospective rate determined under this subpart.

(c) *Geographic adjustment.* National ASC payment rates established under § 416.171 for covered surgical procedures are adjusted for variations in ASC labor costs across geographic areas using wage index values, labor and non-labor percentages, and localities specified by the Secretary.

(d) *Deductibles and coinsurance.* Part B deductible and coinsurance amounts apply as specified in § 410.152(a) and (i) of this chapter.

(e) *Payment reductions for multiple surgical procedures.* (1) *General rule.* Except as provided in paragraph (e)(2) of this section, when more than one surgical procedure for which payment is made under the ASC prospective payment system is performed during an operative session, the Medicare program payment amount and the beneficiary copayment amount are based on—

(i) The full amounts for the procedure with the highest APC payment rate; and

(ii) One-half of the full program and the beneficiary payment amounts for all other covered procedures.

(2) *Exception.* The Secretary may apply any policies or procedures used with respect to multiple procedures under the prospective payment system for hospital outpatient department services under part 419 of this chapter as may be consistent with the equitable and efficient administration of part 416.

§ 416.173 Publication of revised payment methodologies and payment rates.

CMS will publish annually through notice and comment rulemaking in the **Federal Register**, the payment methodologies, payment rates and surgical procedures for which CMS will make an ASC facility payment, and other revisions as appropriate.

§ 416.178 Limitations on administrative and judicial review.

There is no administrative or judicial review under sections 1869 of the Act, section 1878 of the Act or otherwise of the following:

(a) The APC classification system;

(b) Relative payment weights;

(c) Payment amounts; or

(d) Geographic adjustment factors.

18. Redesignated Subpart G is revised to read as follows:

Subpart G—Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Service Centers

Sec.

416.180 Basis and scope.
416.185 Process for establishing a new class of new technology IOLs.
416.190 Request for review of payment amount.
416.195 Determination of membership in new classes of new technology IOLs.
416.200 Payment adjustment.

§ 416.180 Basis and scope.

(a) *Basis.* This subpart implements section 141 of Public Law 103–432, which provides for adjustments to payment amounts for new technology intraocular lenses (IOLs) furnished at ambulatory surgical centers (ASCs).

(b) *Scope.* This subpart sets forth—

(1) The process for interested parties to request that CMS review the appropriateness of the ASC facility fee for insertion of an IOL. This process includes a review of whether that payment is reasonable and related to the cost of acquiring a lens determined by CMS as belonging to a class of new technology IOLs;

(2) Factors that CMS considers for determination of a new class of new technology IOLs; and

(3) Application of the payment adjustment.

§ 416.185 Process for establishing a new class of new technology IOLs.

(a) *Announcement of deadline for requests for review.* CMS announces the deadline for each year's requests for review of a new class of new technology IOLs in the final rule updating the ASC payment rates for that calendar year.

(b) *Announcement of new classes of new technology IOLs for which review requests have been made and solicitation of public comments.* CMS announces the requests for review received in a calendar year and the deadline for public comments regarding the requests in the proposed rule updating the ASC payment rates for the following calendar year. The deadline for submission of public comments is 30 days following the date of the publication of the proposed rule.

(c) *Announcement of determinations regarding requests for review.* CMS announces its determinations for a calendar year in the final rule updating the ASC payment rates for the following calendar year. CMS publishes the codes and effective dates allowed for those lenses recognized by CMS as belonging to a class of new technology IOLs. New classes of new technology IOLs are effective 30 days following the date of publication of the final rule.

§ 416.190 Request for review of payment amount.

(a) *When requests can be submitted.* A request for review of the appropriateness of ASC payment for insertion of an IOL that might qualify for a payment adjustment as belonging to a new class of new technology IOLs must be submitted to CMS in accordance with the annual published deadline.

(b) *Who may submit a request.* Any individual, partnership, corporation, association, society, scientific or academic establishment, or professional or trade organization able to furnish the information required in paragraph(c) of this section may request that CMS review the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act with respect to an IOL that meets the criteria of a new technology IOL under § 416.195.

(c) *Content of a request.* In order to be accepted by CMS for review, a request for review of the ASC payment amount for insertion of an IOL must include all the information as specified by CMS.

(d) *Confidential information.* In order for CMS to invoke the protection allowed under Exemption 4 of the Freedom of Information Act (5 U.S.C. 552(b)(4)) and, with respect to trade secrets, the Trade Secrets Act (18 U.S.C. 1905), the requestor must clearly identify all information that is to be characterized as confidential.

§ 416.195 Determination of membership in new classes of new technology IOLs.

(a) *Factors to be considered.* CMS uses the following criteria to determine whether an IOL qualifies for a payment adjustment as a member of a new class of new technology IOLs when inserted at an ASC.

(1) The IOL is approved by the FDA.

(2) Claims of specific clinical benefits and/or lens characteristics with established clinical relevance in comparison to currently available IOLs are approved by the FDA for use in labeling and advertising.

(3) The IOL is not described by an active or expired class of new technology IOLs; that is, it does not share a predominant, class-defining characteristic associated with improved clinical outcomes with members of an active or expired class.

(4) Evidence demonstrated that use of the IOL results in measurable, clinically meaningful, improved outcomes in comparison with use of currently available IOLs. Superior outcomes include:

(i) Reduced risk of intraoperative or postoperative complication or trauma;

(ii) Accelerated postoperative recovery;

(iii) Reduced induced astigmatism;

(iv) Improved postoperative visual acuity;

(v) More stable postoperative vision;

(vi) Other comparable clinical advantages.

(b) *CMS determination of eligibility for payment adjustment.* CMS reviews the information submitted with a completed request for review, public comments submitted timely, and other pertinent information and makes a determination as follows:

(1) The IOL is eligible for a payment adjustment as a member of a new class of new technology IOLs.

(2) The IOL is a member of an active class of new technology IOLs and is eligible for a payment adjustment for the remainder of the period established for that class.

(3) The IOL does not meet the criteria for designation as a new technology IOL and a payment adjustment is not appropriate.

§ 416.200 Payment adjustment.

(a) CMS establishes the amount of the payment adjustment for classes of new technology IOLs through proposed and final rulemaking in connection with ASC center services.

(b) CMS adjusts the payment for insertion of an IOL approved as belonging to a class of new technology IOLs for the 5-year period of time established for that class.

(c) Upon expiration of the 5-year period of the payment adjustment, payment reverts to the standard rate for IOL insertion procedures performed in ASCs.

(d) ASCs that furnish an IOL designated by CMS as belonging to a class of new technology IOLs must submit claims using billing codes specified by CMS to receive the new technology IOL payment adjustment.

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

19. The authority citation for part 419 continues to read as follows:

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

20. Section 419.21 is amended by revising the introductory text of paragraph (d) to read as follows:

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

* * * * *

(d) The following medical and other health services furnished by a home health agency (HHA) to patients who are not under an HHA plan or treatment or by a hospice program furnishing services to patients outside the hospice benefit:

* * * * *

21. Section 419.43 is amended by adding a new paragraph (h) to read as follows:

§ 419.43 Adjustments to national program payment and beneficiary copayment amounts.

* * * * *

(h) *Applicable adjustments to conversion factor for CY 2007 and for subsequent calendar years.*

(1) *General rule.* For CY 2007, the applicable adjustment to the conversion factor specified in § 419.32(b)(iv) is reduced by 2.0 percentage points for any hospital that has its annual percentage change reduced under § 412.64(d)(2) of this chapter for the corresponding fiscal year. For subsequent years, the applicable adjustment to the conversion factor is reduced for any hospital that

fails to satisfy quality reporting requirements as designated by CMS.

(2) *Limitation.* Any reduction to a hospital's adjustment to its conversion factor specified in § 419.32(b)(iv) which occurs as a result of paragraph (h)(1) of this section will apply only to the calendar year involved and will not be taken into account in computing that hospital's applicable adjustment for a subsequent calendar year.

(3) *Budget neutrality.* For CY 2007 and for each subsequent calendar year, CMS makes an adjustment to the conversion factor, so that estimated aggregate payments under the OPPS for such calendar year are not affected by any reductions to hospital adjustments which occur as a result of paragraph (h)(1) of this section.

22. A new section 419.45 is added to read as follows:

§ 419.45 Payment and copayment reduction for devices replaced under warranty or as a result of recall.

(a) *General rule.* CMS reduces the amount of payment for an implanted device made under the hospital outpatient prospective payment system in accordance with § 419.66 for which CMS determines that a significant portion of the payment is attributable to the cost of an implanted device, when one of the following situations occur:

(1) The device is replaced without cost to the provider or the beneficiary; or

(2) The provider receives full credit for the cost of a replaced device.

(b) *Amount of reduction to the APC payment.* The amount of the reduction to the APC payment made under paragraph (a) of this section is calculated in the same manner as the offset amount that would be applied if the device implanted in a procedure assigned to the APC had transitional pass-through status under § 419.66.

(c) *Amount of beneficiary copayment.* The beneficiary copayment is calculated based on the APC payment after application of the reduction under paragraph (b) of this section.

23. Section 419.70 is amended by—

a. Revising paragraph (d)(1).

b. Redesignating paragraphs (d)(2) and (d)(3) as paragraphs (d)(3) and (d)(4), respectively.

c. Adding a new paragraph (d)(2).

The revisions and addition read as follows:

§ 419.70 Transitional adjustment to limit decline in payments.

* * * * *

(d) *Hold harmless provisions.*—(1) *Temporary treatment for small rural hospitals before January 1, 2006.* For covered hospital outpatient services furnished in a calendar year before January 1, 2006, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by the amount of that difference if the hospital—

(i) Is located in a rural area as defined in § 412.63(b) of this chapter or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act; and

(ii) Has 100 or fewer beds as defined in § 412.105(b) of this chapter.

(2) *Temporary treatment for small rural hospitals on or after January 1, 2006.* For covered hospital outpatient services furnished in a calendar year from January 1, 2006, through December 31, 2008, for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this paragraph is increased by 95 percent of that difference for services furnished during 2006, 90 percent of that difference for services furnished during 2007, and 85 percent of that difference for services furnished during 2008 if the hospital—

(i) Is located in a rural area as defined in § 412.63(b) of this chapter or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act;

(ii) Has 100 or fewer beds as defined in § 412.105(b) of this chapter;

(iii) Is not a sole community hospital as defined in § 412.92 of this chapter; and

(iv) Is not an essential access community hospital under § 412.109 of this chapter.

* * * * *

PART 421—MEDICARE CONTRACTING

24. The heading of part 421 is revised to read as set out above.

25. The authority citation for part 421 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

26. Section 421.3 is revised to read as follows:

§ 421.3 Definitions.

As used in this part—

Intermediary means an entity that has a contract with CMS (under statutory provisions in effect prior to October 1, 2005) to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis (or under the prospective payment system for hospitals) and to perform other related functions. For purposes of applying the performance criteria in § 421.120 and the performance standards in § 421.122 and any adverse action resulting from that application, the term ''intermediary'' also means a Blue Cross plan that has entered into a subcontract approved by CMS with the Blue Cross and Blue Shield Association to perform intermediary functions.

27. Section 421.100 is amended by revising paragraph (i) to read as follows:

§ 421.100 Intermediary functions.

* * * * *

(i) *Dual intermediary responsibilities.* Regarding the responsibility for service to provider-based HHAs and provider-based hospices, where the HHA or the hospice and its parent provider will be served by different intermediaries, the designated regional intermediary will process bills, make coverage determinations, and make payments to the HHAs and the hospices. The intermediary serving the parent provider will perform all fiscal functions, including audits and settlement of the Medicare cost reports and the HHA and hospice supplement worksheets.

28. Section 421.103 is revised to read as follows:

§ 421.103 Payment to providers.

Providers are assigned to intermediaries in accordance with § 421.104. As the Medicare Administrative Contractors (MACs) are implemented, providers are reassigned from intermediaries to MACs in accordance with § 412.404.

29. Section 421.104 is revised to read as follows:

§ 421.104 Assignment of providers of services to intermediaries during transition to Medicare administrative contractors (MACs).

(a) Beginning October 1, 2005, CMS assigns providers of services and other entities that may bill Part A benefits to intermediaries in a manner that will best support the transition to Medicare administrative contractors (MACs) under section 1874A of the Act in accordance with Subpart E of this part.

(b) These providers of services and other entities must continue to bill the intermediary that they were billing prior to October 1, 2005, until one of the following events occurs:

(1) The intermediary's agreement with CMS ends, and the provider or entity is directed by CMS to bill another CMS contractor.

(2) The provider or entity is assigned to a MAC that has begun to administer claims within the geographic locale of the provider or entity.

(3) CMS directs the provider or entity to begin billing another CMS contractor in order to support the implementation

of MACs under section 1874A of the Act and Subpart E of this part.

(c) New providers of services and new entities will be assigned to the intermediary serving their geographic locale if no MAC has begun to administer Medicare claims in the locale. These providers or entities must continue to bill the intermediary until one of the events in paragraph (b) of this section occurs.

(d) Providers or entities will only be granted exceptions to the provisions of paragraphs (b) or (c) of this section if CMS deems the exception to be in the compelling interest of the Medicare program.

(e) CMS will notify the provider or entity, the outgoing intermediary, and the newly assigned intermediary of assignment or reassignment decisions.

§ 421.105 [Removed]

30. Section 421.105 is removed.

§ 421.106 [Removed]

31. Section 421.106 is removed.

32. Section 421.112 is amended by—

a. Revising paragraph (a).

b. Revising paragraph (b).

The revisions read as follows:

§ 421.112 Considerations relating to the effective and efficient administration of the program.

(a) In order to accomplish the most effective and efficient administration of the Medicare program, the Secretary may make determinations with respect to the termination of an intermediary agreement, and CMS may make determinations with respect to renewal of an intermediary agreement under § 421.110.

(b) When taking the actions specified in paragraph (a) of this section, the Secretary or CMS will consider the performance of the individual intermediary in its Medicare operations using the factors contained in the performance criteria specified in § 421.120 and the performance standards specified in section § 421.122.

* * * * *

33. Section 421.114 is revised to read as follows:

§ 421.114 Assignment and reassignment of providers by CMS.

CMS may assign or reassign any provider to any intermediary if it determines that the assignment or reassignment will be in the best interests of the Medicare program.

§ 421.116 [Removed]

34. Section 421.116 is removed.

§ 421.117 [Removed]

35. Section 421.117 is removed.

§ 421.118 [Removed]

36. Section 421.118 is removed.

37. Reserve Subpart D and add a new Subpart E to Part 421 to read as follows:

Subpart E—Medicare Administrative Contractors (MACs)

Sec.
421.400 Statutory basis and scope.
421.401 Definitions.
421.404 Assignment of providers and suppliers to MACs.

§ 421.400 Statutory basis and scope.

(a) *Statutory basis.* This subpart implements section 1874A of the Act, which provides for the transition of the claims processing functions and operations for both Medicare Part A and Part B intermediaries and carriers to Medicare administrative contractors (MACs). The transition will occur between October 1, 2005, and October 1, 2011. MACs will be fully operational in distinct, nonoverlapping geographic jurisdictions by October 1, 2011.

(b) *Scope.* This subpart specifies the requirements under which providers and suppliers will be assigned to MACs.

§ 421.401 Definitions.

For purposes of this subpart—

Appropriate MAC means a MAC that has a contract under section 1874A of the Act to perform a particular Medicare administrative function in relation to:

(1) A particular individual entitled to benefits under Part A or enrolled under Part B, or both;

(2) A specific provider of services or supplier; or

(3) A class of providers of services or suppliers.

Medicare administrative contractor (MAC) means an agency, organization, or other person with a contract under section 1874A of the Act.

§ 421.404 Assignment of providers and suppliers to MACs.

(a) *Definitions.* As used in this section—

Chain provider means a group of two or more providers under common ownership or control.

Common control exists when an individual, a group of individuals, or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of the group of suppliers or eligible providers.

Common ownership exists when an individual, a group of individuals, or an organization possesses significant equity in the group of suppliers or eligible providers.

Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) means the types of services specified in § 421.210(b).

Eligible provider means a hospital, skilled nursing facility, or critical access hospital that meets the definition of a provider under § 400.202 of this chapter.

Home office means the entity that provides centralized management and administrative services to the individual providers or suppliers under common ownership and common control, such as centralized accounting, purchasing, personnel services, management direction and control, and other similar services.

Ineligible provider means a provider under § 400.202 of this chapter that is not an eligible provider.

Medicare benefit category means a category of covered benefits under Part A or Part B of the Medicare program (for example, inpatient hospital services, post-hospital extended care services, and physicians' services).

Provider has the same meaning as specified under § 400.202 of this chapter.

Qualified chain provider means a chain provider comprised of—

(1) 10 or more eligible providers collectively totaling 500 or more certified beds; or

(2) 5 or more eligible providers collectively totaling 300 or more certified beds, with eligible providers in 3 or more continuous States.

Supplier has the same meaning as specified in § 400.202 of this chapter.

(b) *Assignment of providers to MACs.* (1) Providers enroll with and receive Medicare payment and other Medicare services from the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the provider's covered services for the geographic locale in which the provider is physically located.

(2) Qualified chain providers may request and receive an exception from the requirement of paragraph (b)(1) of this section from CMS. Upon CMS' approval, a qualified chain provider may enroll with and bill on behalf of the eligible providers under its common ownership or common control to the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the eligible providers' covered services for the geographic locale in which the qualified chain provider's home office is physically located.

(3) As MAC contractors become available, qualified chain providers, granted approval by CMS to enroll with and bill a single intermediary on behalf of their eligible member providers prior to October 1, 2005, will be assigned at an appropriate time to the MAC contracted by CMS to administer claims

for the applicable Medicare benefit category for the geographic locale in which the chain provider's home office is physically located. The qualified chain provider will not need to request an exception to the requirement of paragraph (b)(1) of this section in order for this assignment to take effect.

(4) CMS may grant an exception to the requirement of paragraph (b)(1) of this section to eligible providers that are not under the common ownership or common control of a qualified chain provider, as well as ineligible providers, only if CMS finds the exception will support the implementation of MACs or will serve some other compelling interest of the Medicare program.

(c) *Assignment of suppliers to MACs.* (1) Suppliers, including physicians and other practitioners, but excluding suppliers of DMEPOS, enroll with and receive Medicare payment and other Medicare services from the MAC contracted by CMS to administer claims for the Medicare benefit category applicable to the supplier's covered services for the geographic locale in which the supplier furnished such services.

(2) Suppliers of DMEPOS receive Medicare payment and other Medicare services from the MAC assigned to administer claims for DMEPOS for the regional area in which the beneficiary receiving the DMEPOS resides. The terms of §§ 421.210 and 421.212 continue to apply to suppliers of DMEPOS.

(3) CMS may allow a group of ESRD suppliers under common ownership and common control to enroll with the MAC contracted by CMS to administer ESRD claims for the geographic locale in which the group's home office is located only if—

(i) The group of ESRD suppliers requests such privileges; and

(ii) CMS finds the exception will support the implementation of MACs or will serve some other compelling interest of the Medicare program.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

38. The authority citation for Part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

39. Section 485.618 is amended by—

a. Revising paragraph (d)(1) introductory text.

b. Redesignating paragraphs (d)(2) and (d)(3) as paragraphs (d)(3) and (d)(4), respectively.

c. Adding a new paragraph (d)(2).

d. In redesignated paragraph (d)(3)(iv), removing the cross-reference ''paragraph (d)(2)(iii)'' and adding the cross-reference ''paragraph (d)(3)(iii)'' in its place.

e. In redesignated paragraph (d)(4), removing the cross-reference ''paragraph (d)(2)(iii)'' and adding the cross-reference ''paragraph (d)(3)(iii)'' in its place.

The revisions and additions read as follows:

§ 485.618 Condition of participation: Emergency services.

* * * * *

(d) *Standard: Personnel.*

(1) Except as specified in paragraph (d)(3) of this section, there must be a doctor of medicine or osteopathy, a physician assistant, a nurse practitioner, or a clinical nurse specialist, with training or experience in emergency care, on call and immediately available by telephone or radio contact, and available onsite within the following timeframes:

* * * * *

(2) A registered nurse with training and experience in emergency care can be utilized to conduct specific medical screening examinations only if—

(i) The registered nurse is on site and immediately available at the CAH when a patient requests medical care; and

(ii) The nature of the patient's request for medical care is within the scope of practice of a registered nurse and consistent with applicable State laws.

* * * * *

PART 488—SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

40. The authority citation for part 488 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

41. In § 488.1, the definition of ''supplier'' is revised to read as follows:

§ 488.1 Definitions.

* * * * *

Supplier means any of the following: Independent laboratory; portable X-ray services; physical therapist in independent practice; ESRD facility; rural health clinic; Federally qualified health center; chiropractor; or ambulatory surgical center.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)
(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: July 28, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: August 7, 2006.

Michael O. Leavitt,

Secretary.

ADDENDUM A.—OPPS PROPOSED LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
0001	Level I Photochemotherapy	S	0.4896	30.14	7.00	6.03
0002	Level I Fine Needle Biopsy/Aspiration	T	1.0948	67.39		13.48
0003	Bone Marrow Biopsy/Aspiration	T	2.4295	149.54		29.91
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow	T	2.0863	128.41		25.68
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	3.8051	234.21	71.59	46.84
0006	Level I Incision & Drainage	T	1.4821	91.22	21.76	18.24
0007	Level II Incision & Drainage	T	10.9184	672.04		134.41
0008	Level III Incision and Drainage	T	17.4686	1,075.21		215.04
0009	Nail Procedures	T	0.6803	41.87		8.37
0010	Level I Destruction of Lesion	T	0.4829	29.72	8.14	5.94
0011	Level II Destruction of Lesion	T	2.6478	162.97		32.59
0012	Level I Debridement & Destruction	T	0.8076	49.71	10.30	9.94
0013	Level II Debridement & Destruction	T	1.0876	66.94		13.39
0015	Level III Debridement & Destruction	T	1.6062	98.86	20.13	19.77
0016	Level IV Debridement & Destruction	T	2.6253	161.59	32.68	32.32
0017	Level VI Debridement & Destruction	T	17.7392	1,091.87	227.84	218.37
0018	Biopsy of Skin/Puncture of Lesion	T	1.0534	64.84	15.87	12.97
0019	Level I Excision/ Biopsy	T	4.0123	246.96	71.87	49.39
0020	Level II Excision/ Biopsy	T	6.5128	400.87	98.57	80.17
0021	Level III Excision/ Biopsy	T	14.9563	920.58	219.48	184.12
0022	Level IV Excision/ Biopsy	T	19.9760	1,229.54	354.45	245.91
0023	Exploration Penetrating Wound	T	4.1133	253.18		50.64
0024	Level I Skin Repair	T	1.4924	91.86	30.08	18.37
0025	Level II Skin Repair	T	5.0931	313.49	95.46	62.70
0027	Level IV Skin Repair	T	21.2645	1,308.85	329.72	261.77
0028	Level I Breast Surgery	T	19.2250	1,183.32	303.74	236.66
0029	Level II Breast Surgery	T	28.1505	1,732.69		346.54
0030	Level III Breast Surgery	T	40.7495	2,508.17	763.55	501.63
0031	Smoking Cessation Services	X	0.1716	10.56		2.11
0033	Partial Hospitalization	P	3.3837	208.27		41.65
0035	Arterial/Venous Puncture	T	0.2016	12.41		2.48
0036	Level II Fine Needle Biopsy/Aspiration	T	2.0147	124.01		24.80
0037	Level IV Needle Biopsy/Aspiration Except Bone Marrow	T	10.2616	631.61	228.76	126.32
0038	Spontaneous MEG	S	51.2627	3,155.27		631.05
0039	Level I Implantation of Neurostimulator	S	175.9328	10,828.84		2,165.77
0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	S	56.3855	3,470.58		694.12
0041	Level I Arthroscopy	T	28.6279	1,762.08		352.42
0042	Level II Arthroscopy	T	45.0637	2,773.72	804.74	554.74
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.6914	104.11		20.82
0045	Bone/Joint Manipulation Under Anesthesia	T	14.5502	895.58	268.47	179.12
0047	Arthroplasty without Prosthesis	T	32.7543	2,016.06	537.03	403.21
0048	Level I Arthroplasty with Prosthesis	T	47.1644	2,903.02		580.60
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	20.8214	1,281.58		256.32
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	25.0600	1,542.47		308.49
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	41.2543	2,539.24		507.85
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	65.8846	4,055.26		811.05
0053	Level I Hand Musculoskeletal Procedures	T	16.0343	986.93	253.49	197.39
0054	Level II Hand Musculoskeletal Procedures	T	25.8425	1,590.63		318.13
0055	Level I Foot Musculoskeletal Procedures	T	20.2255	1,244.90	355.34	248.98
0056	Level II Foot Musculoskeletal Procedures	T	41.2239	2,537.37		507.47
0057	Bunion Procedures	T	28.0970	1,729.40	475.91	345.88
0058	Level I Strapping and Cast Application	S	1.0504	64.65		12.93
0060	Manipulation Therapy	S	0.4904	30.18		6.04
0061	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	S	84.2373	5,184.89		1,036.98
0062	Level I Treatment Fracture/Dislocation	T	25.6702	1,580.03	375.46	316.01
0063	Level II Treatment Fracture/Dislocation	T	37.5680	2,312.35	549.49	462.47
0064	Level III Treatment Fracture/Dislocation	T	56.4195	3,472.68	825.22	694.54
0065	Level I Stereotactic Radiosurgery	S	22.4428	1,381.38		276.28
0066	Level II Stereotactic Radiosurgery	S	47.2213	2,906.52		581.30
0067	Level III Stereotactic Radiosurgery	S	65.7255	4,045.47		809.09
0068	CPAP Initiation	S	1.3718	84.44	29.48	16.89
0069	Thoracoscopy	T	31.5464	1,941.71	591.64	388.34
0070	Thoracentesis/Lavage Procedures	T	3.6425	224.20		44.84
0071	Level I Endoscopy Upper Airway	T	0.7572	46.61	11.03	9.32
0072	Level II Endoscopy Upper Airway	T	1.4038	86.41	21.27	17.28
0073	Level III Endoscopy Upper Airway	T	3.8737	238.43	69.72	47.69
0074	Level IV Endoscopy Upper Airway	T	15.1300	931.27	295.70	186.25

ADDENDUM A.—OPPS PROPOSED LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
0075	Level V Endoscopy Upper Airway	T	21.8010	1,341.87	445.92	268.37
0076	Level I Endoscopy Lower Airway	T	9.3905	577.99	189.82	115.60
0077	Level I Pulmonary Treatment	S	0.3383	20.82	7.74	4.16
0078	Level II Pulmonary Treatment	S	1.0381	63.90	14.55	12.78
0079	Ventilation Initiation and Management	S	2.7732	170.69		34.14
0080	Diagnostic Cardiac Catheterization	T	37.1008	2,283.59	838.92	456.72
0081	Non-Coronary Angioplasty or Atherectomy	T	42.8894	2,639.89		527.98
0082	Coronary Atherectomy	T	76.2006	4,690.22	1,008.90	938.04
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	57.4937	3,538.79		707.76
0084	Level I Electrophysiologic Evaluation	S	9.9197	610.57		122.11
0085	Level II Electrophysiologic Evaluation	T	34.7086	2,136.35		427.27
0086	Ablate Heart Dysrhythm Focus	T	47.1472	2,901.96	812.36	580.39
0087	Cardiac Electrophysiologic Recording/Mapping	T	32.8298	2,020.71		404.14
0088	Thrombectomy	T	37.9652	2,336.80	655.22	467.36
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes	T	121.9402	7,505.54	1,682.28	1,501.11
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	97.8357	6,021.89	1,612.80	1,204.38
0091	Level II Vascular Ligation	T	34.6279	2,131.38		426.28
0092	Level I Vascular Ligation	T	24.5817	1,513.03	306.56	302.61
0093	Vascular Reconstruction/Fistula Repair without Device	T	21.9703	1,352.29		270.46
0094	Level I Resuscitation and Cardioversion	S	2.4630	151.60	46.29	30.32
0095	Cardiac Rehabilitation	S	0.5792	35.65	13.86	7.13
0096	Non-Invasive Vascular Studies	S	1.5727	96.80	38.13	19.36
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0245	63.06	23.79	12.61
0098	Injection of Sclerosing Solution	T	1.1035	67.92		13.58
0099	Electrocardiograms	S	0.3835	23.60		4.72
0100	Cardiac Stress Tests	X	2.5352	156.04	41.44	31.21
0101	Tilt Table Evaluation	S	4.3122	265.42	100.24	53.08
0103	Miscellaneous Vascular Procedures	T	17.0436	1,049.05	223.63	209.81
0104	Transcatheter Placement of Intracoronary Stents	T	87.9808	5,415.31		1,083.06
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	23.4666	1,444.39	370.40	288.88
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	44.7574	2,754.86		550.97
0107	Insertion of Cardioverter-Defibrillator	T	279.2049	17,185.34		3,437.07
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads	T	370.5535	22,807.94		4,561.59
0109	Removal of Implanted Devices	T	10.9541	674.24		134.85
0110	Transfusion	S	3.4570	212.78		42.56
0111	Blood Product Exchange	S	11.7005	720.18	198.40	144.04
0112	Apheresis, Photopheresis, and Plasmapheresis	S	30.6602	1,887.17	433.29	377.43
0113	Excision Lymphatic System	T	21.3673	1,315.18		263.04
0114	Thyroid/Lymphadenectomy Procedures	T	37.1283	2,285.28	461.19	457.06
0115	Cannula/Access Device Procedures	T	29.4757	1,814.26	378.68	362.85
0121	Level I Tube changes and Repositioning	T	2.3431	144.22	43.80	28.84
0122	Level II Tube changes and Repositioning	T	7.2859	448.45		89.69
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	23.2490	1,431.00		286.20
0125	Refilling of Infusion Pump	T	2.2200	136.64		27.33
0126	Level I Urinary and Anal Procedures	T	1.0844	66.75	16.40	13.35
0127	Level IV Stereotactic Radiosurgery	S	126.8566	7,808.15		1,561.63
0130	Level I Laparoscopy	T	31.9353	1,965.65	659.53	393.13
0131	Level II Laparoscopy	T	43.5124	2,678.23	1,001.89	535.65
0132	Level III Laparoscopy	T	70.8854	4,363.07	1,239.22	872.61
0140	Esophageal Dilation without Endoscopy	T	5.3134	327.05	91.40	65.41
0141	Level I Upper GI Procedures	T	8.3070	511.30	143.38	102.26
0142	Small Intestine Endoscopy	T	9.3878	577.83	152.78	115.57
0143	Lower GI Endoscopy	T	8.8143	542.53	186.06	108.51
0146	Level I Sigmoidoscopy and Anoscopy	T	4.8005	295.48	64.40	59.10
0147	Level II Sigmoidoscopy and Anoscopy	T	8.5644	527.15		105.43
0148	Level I Anal/Rectal Procedures	T	4.8970	301.42		60.28
0149	Level III Anal/Rectal Procedures	T	22.2336	1,368.50	293.06	273.70
0150	Level IV Anal/Rectal Procedures	T	29.4386	1,811.98	437.12	362.40
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	19.8125	1,219.48	245.46	243.90
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	19.4515	1,197.26		239.45
0153	Peritoneal and Abdominal Procedures	T	22.1758	1,364.94	397.95	272.99
0154	Hernia/Hydrocele Procedures	T	29.1491	1,794.16	464.85	358.83
0155	Level II Anal/Rectal Procedures	T	12.8778	792.64		158.53
0156	Level III Urinary and Anal Procedures	T	3.5688	219.66		43.93
0157	Colorectal Cancer Screening: Barium Enema	S	2.4974	153.72		30.74
0158	Colorectal Cancer Screening: Colonoscopy	T	7.8134	480.92		120.23
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	3.8973	239.88		59.97
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	6.7325	414.39	105.06	82.88
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	19.2766	1,186.49	249.36	237.30

ADDENDUM A.—OPPS PROPOSED LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCs) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	23.8562	1,468.37		293.67
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	35.1024	2,160.59		432.12
0164	Level II Urinary and Anal Procedures	T	2.1159	130.24		26.05
0165	Level IV Urinary and Anal Procedures	T	18.2333	1,122.28		224.46
0166	Level I Urethral Procedures	T	18.5138	1,139.54		227.91
0168	Level II Urethral Procedures	T	28.5971	1,760.18	388.16	352.04
0169	Lithotripsy	T	44.1144	2,715.29	1,009.47	543.06
0170	Dialysis	S	6.8096	419.14		83.83
0171	Level V Anal/Rectal Procedures	T	37.2425	2,292.31	705.28	458.46
0180	Circumcision	T	20.7418	1,276.68	304.87	255.34
0181	Penile Procedures	T	32.9991	2,031.13	621.82	406.23
0183	Testes/Epididymis Procedures	T	23.7072	1,459.20		291.84
0184	Prostate Biopsy	T	5.9892	368.64	96.27	73.73
0188	Level II Female Reproductive Proc	T	1.4050	86.48		17.30
0189	Level III Female Reproductive Proc	T	2.9902	184.05		36.81
0190	Level I Hysteroscopy	T	21.4199	1,318.42	424.28	263.68
0191	Level I Female Reproductive Proc	T	0.1501	9.24		1.85
0192	Level IV Female Reproductive Proc	T	6.9265	426.33		85.27
0193	Level V Female Reproductive Proc	T	14.7958	910.70		182.14
0194	Level VIII Female Reproductive Proc	T	20.5113	1,262.49	397.84	252.50
0195	Level IX Female Reproductive Proc	T	28.7410	1,769.04	483.80	353.81
0196	Dilation and Curettage	T	17.7635	1,093.36	338.23	218.67
0197	Infertility Procedures	T	4.4108	271.49		54.30
0198	Pregnancy and Neonatal Care Procedures	T	1.4026	86.33	32.19	17.27
0200	Level VII Female Reproductive Proc	T	17.2607	1,062.41	248.39	212.48
0201	Level VI Female Reproductive Proc	T	18.5251	1,140.24	329.65	228.05
0202	Level X Female Reproductive Proc	T	42.8756	2,639.04	981.50	527.81
0203	Level IV Nerve Injections	T	12.4432	765.89	240.33	153.18
0204	Level I Nerve Injections	T	2.2491	138.43	40.13	27.69
0206	Level II Nerve Injections	T	5.5439	341.23	75.55	68.25
0207	Level III Nerve Injections	T	6.3788	392.62	86.92	78.52
0208	Laminotomies and Laminectomies	T	43.9030	2,702.27		540.45
0209	Level II MEG, Extended EEG Studies and Sleep Studies	S	11.4847	706.89	268.73	141.38
0212	Nervous System Injections	T	3.0383	187.01	65.96	37.40
0213	Level I MEG, Extended EEG Studies and Sleep Studies	S	2.3133	142.39	53.58	28.48
0214	Electroencephalogram	S	1.2353	76.03	28.24	15.21
0215	Level I Nerve and Muscle Tests	S	0.5760	35.45		7.09
0216	Level III Nerve and Muscle Tests	S	2.6729	164.52		32.90
0218	Level II Nerve and Muscle Tests	S	1.1993	73.82		14.76
0220	Level I Nerve Procedures	T	17.7609	1,093.20		218.64
0221	Level II Nerve Procedures	T	33.3035	2,049.86	463.62	409.97
0222	Implantation of Neurological Device	T	178.1307	10,964.12		2,192.82
0223	Implantation or Revision of Pain Management Catheter	T	29.2931	1,803.02		360.60
0224	Implantation of Reservoir/Pump/Shunt	T	45.6712	2,811.11		562.22
0225	Implantation of Neurostimulator Electrodes, Cranial Nerve	S	234.1628	14,412.95		2,882.59
0226	Implantation of Drug Infusion Reservoir	T	112.0147	6,894.62		1,378.92
0227	Implantation of Drug Infusion Device	T	183.1974	11,275.98		2,255.20
0228	Creation of Lumbar Subarachnoid Shunt	T	36.1603	2,225.70		445.14
0229	Transcatherter Placement of Intravascular Shunts	T	66.0804	4,067.31		813.46
0230	Level I Eye Tests & Treatments	S	0.8126	50.02	14.97	10.00
0231	Level III Eye Tests & Treatments	S	2.1934	135.01		27.00
0232	Level I Anterior Segment Eye Procedures	T	5.9800	368.07	92.21	73.61
0233	Level II Anterior Segment Eye Procedures	T	14.9969	923.07	266.33	184.61
0234	Level III Anterior Segment Eye Procedures	T	22.9479	1,412.47	511.31	282.49
0235	Level I Posterior Segment Eye Procedures	T	4.0750	250.82	61.14	50.16
0236	Level II Posterior Segment Eye Procedures	T	16.3433	1,005.95		201.19
0237	Level III Posterior Segment Eye Procedures	T	26.9305	1,657.60		331.52
0238	Level I Repair and Plastic Eye Procedures	T	2.8099	172.95		34.59
0239	Level II Repair and Plastic Eye Procedures	T	6.9354	426.88		85.38
0240	Level III Repair and Plastic Eye Procedures	T	17.0126	1,047.14	307.90	209.43
0241	Level IV Repair and Plastic Eye Procedures	T	24.8502	1,529.55	384.47	305.91
0242	Level V Repair and Plastic Eye Procedures	T	35.5217	2,186.40	597.36	437.28
0243	Strabismus/Muscle Procedures	T	21.2885	1,310.33	431.09	262.07
0244	Corneal Transplant	T	37.9446	2,335.53	803.26	467.11
0245	Level I Cataract Procedures without IOL Insert	T	14.5427	895.12	217.05	179.02
0246	Cataract Procedures with IOL Insert	T	23.5664	1,450.54	495.96	290.11
0247	Laser Eye Procedures Except Retinal	T	5.1266	315.55	104.31	63.11
0248	Laser Retinal Procedures	T	5.0285	309.51	95.08	61.90
0249	Level II Cataract Procedures without IOL Insert	T	28.5043	1,754.47	524.67	350.89

ADDENDUM A.—OPPS PROPOSED LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
0250	Nasal Cauterization/Packing	T	1.2021	73.99	25.50	14.80
0251	Level I ENT Procedures	T	2.3768	146.29		29.26
0252	Level II ENT Procedures	T	7.7261	475.55	111.84	95.11
0253	Level III ENT Procedures	T	16.4494	1,012.48	282.29	202.50
0254	Level IV ENT Procedures	T	23.1564	1,425.30	321.35	285.06
0256	Level V ENT Procedures	T	37.7719	2,324.90		464.98
0257	Level I Therapeutic Radiologic Procedures	S	0.9770	60.14		12.03
0258	Tonsil and Adenoid Procedures	T	22.7757	1,401.87	437.25	280.37
0259	Level VI ENT Procedures	T	406.8232	25,040.37	8,698.43	5,008.07
0260	Level I Plain Film Except Teeth	X	0.7276	44.78		8.96
0261	Level II Plain Film Except Teeth Including Bone Density Measurement	X	1.2515	77.03		15.41
0262	Plain Film of Teeth	X	0.5818	35.81		7.16
0263	Level I Miscellaneous Radiology Procedures	X	1.7120	105.38	23.77	21.08
0264	Level II Miscellaneous Radiology Procedures	X	2.9791	183.37	70.84	36.67
0265	Level I Diagnostic and Screening Ultrasound	S	1.0145	62.44	23.63	12.49
0266	Level II Diagnostic and Screening Ultrasound	S	1.5947	98.16	37.80	19.63
0267	Level III Diagnostic and Screening Ultrasound	S	2.5166	154.90	60.80	30.98
0268	Level I Ultrasound Guidance Procedures	S	1.1967	73.66		14.73
0269	Level II Echocardiogram Except Transesophageal	S	3.2432	199.62	75.60	39.92
0270	Transesophageal Echocardiogram	S	6.2689	385.86	141.32	77.17
0272	Fluoroscopy	X	1.2985	79.92	31.64	15.98
0274	Myelography	S	2.6182	161.15	64.46	32.23
0275	Arthrography	S	3.7021	227.87	69.09	45.57
0276	Level I Digestive Radiology	S	1.4519	89.37	34.97	17.87
0277	Level II Digestive Radiology	S	2.2764	140.11	54.63	28.02
0278	Diagnostic Urography	S	2.4721	152.16	60.84	30.43
0279	Level II Angiography and Venography	S	9.6539	594.21	150.03	118.84
0280	Level III Angiography and Venography	S	20.9479	1,289.36	353.85	257.87
0282	Miscellaneous Computerized Axial Tomography	S	1.5552	95.72	37.92	19.14
0283	Computerized Axial Tomography with Contrast Material	S	4.1858	257.64	102.17	51.53
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contras.	S	6.2589	385.24	148.40	77.05
0288	Bone Density:Axial Skeleton	S	1.2005	73.89		14.78
0293	Level V Anterior Segment Eye Procedures	T	50.6347	3,116.62	1,100.34	623.32
0296	Level II Therapeutic Radiologic Procedures	S	2.7106	166.84	53.99	33.37
0297	Level III Therapeutic Radiologic Procedures	S	3.6483	224.56	89.82	44.91
0298	Level IV Therapeutic Radiologic Procedures	S	8.4904	522.59	209.02	104.52
0299	Miscellaneous Radiation Treatment	S	6.0322	371.29		74.26
0300	Level I Radiation Therapy	S	1.5004	92.35		18.47
0301	Level II Radiation Therapy	S	2.2670	139.54		27.91
0302	Computer Assisted Navigational Procedures	S	5.5005	338.56	105.94	67.71
0303	Treatment Device Construction	X	2.9637	182.42	66.95	36.48
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.6062	98.86	39.54	19.77
0305	Level II Therapeutic Radiation Treatment Preparation	X	4.0232	247.63	91.38	49.53
0307	Myocardial Positron Emission Tomography (PET) imaging	S	11.6773	718.75	287.49	143.75
0308	Non-Myocardial Positron Emission Tomography (PET) imaging	S	14.0093	862.29		172.46
0309	Level II Ultrasound Guidance Procedures	S	2.1284	131.01		26.20
0310	Level III Therapeutic Radiation Treatment Preparation	X	14.0578	865.27	325.27	173.05
0312	Radioelement Applications	S	5.0185	308.89		61.78
0313	Brachytherapy	S	13.3939	824.41		164.88
0314	Hyperthermic Therapies	S	3.6583	225.17	66.65	45.03
0315	Level II Implantation of Neurostimulator	T	235.5774	14,500.02		2,900.00
0320	Electroconvulsive Therapy	S	5.5017	338.64	80.06	67.73
0321	Biofeedback and Other Training	S	1.3693	84.28	21.72	16.86
0322	Brief Individual Psychotherapy	S	1.1749	72.32		14.46
0323	Extended Individual Psychotherapy	S	1.7170	105.68		21.14
0324	Family Psychotherapy	S	2.2087	135.95		27.19
0325	Group Psychotherapy	S	1.0787	66.40	14.51	13.28
0330	Dental Procedures	S	9.5891	590.22		118.04
0332	Computerized Axial Tomography and Computerized Angiography without Contras.	S	3.1631	194.69	75.24	38.94
0333	Computerized Axial Tomography and Computerized Angiography without Contrast followed by Contrast.	S	5.0020	307.88	121.52	61.58
0335	Magnetic Resonance Imaging, Miscellaneous	S	4.6629	287.01	114.80	57.40
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont.	S	5.8500	360.07	139.68	72.01
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed.	S	8.3423	513.48	202.50	102.70
0339	Observation	S	7.1587	440.63		88.13

ADDENDUM A.—OPPS PROPOSED LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
0340	Minor Ancillary Procedures	X	0.6211	38.23		7.65
0341	Skin Tests	X	0.0914	5.63	2.25	1.13
0342	Level I Pathology	X	0.0813	5.00	2.00	1.00
0343	Level III Pathology	X	0.5309	32.68	10.84	6.54
0344	Level IV Pathology	X	0.8107	49.90	15.66	9.98
0345	Level I Transfusion Laboratory Procedures	X	0.2218	13.65	2.87	2.73
0346	Level II Transfusion Laboratory Procedures	X	0.3494	21.51	4.39	4.30
0347	Level III Transfusion Laboratory Procedures	X	0.7394	45.51	11.24	9.10
0348	Fertility Laboratory Procedures	X	0.8928	54.95		10.99
0350	Administration of flu and PPV vaccine	S	0.4107	25.28	0.00	0.00
0360	Level I Alimentary Tests	X	1.3789	84.87	33.88	16.97
0361	Level II Alimentary Tests	X	3.9319	242.01	83.23	48.40
0362	Contact Lens and Spectacle Services	X	0.5328	32.79		6.56
0363	Level I Otorhinolaryngologic Function Tests	X	0.8534	52.53	17.44	10.51
0364	Level I Audiometry	X	0.4637	28.54	7.06	5.71
0365	Level II Audiometry	X	1.2467	76.74	18.52	15.35
0366	Level III Audiometry	X	1.8175	111.87	26.14	22.37
0367	Level I Pulmonary Test	X	0.6253	38.49	14.64	7.70
0368	Level II Pulmonary Tests	X	0.9568	58.89	22.77	11.78
0369	Level III Pulmonary Tests	X	2.8329	174.37	44.18	34.87
0370	Allergy Tests	X	1.0769	66.28		13.26
0372	Therapeutic Phlebotomy	X	0.5814	35.79	10.09	7.16
0373	Level I Neuropsychological Testing	X	1.6262	100.09		20.02
0374	Monitoring Psychiatric Drugs	X	1.1509	70.84		14.17
0375	Ancillary Outpatient Services When Patient Expires	S	57.3014	3,526.96		705.39
0376	Level II Cardiac Imaging	S	4.9770	306.34	119.77	61.27
0377	Level III Cardiac Imaging	S	6.7443	415.12	158.84	83.02
0378	Level II Pulmonary Imaging	S	5.2084	320.58	128.23	64.12
0379	Injection adenosine 6 MG	K		29.90		5.98
0381	Single Allergy Tests	X	0.2151	13.24		2.65
0382	Level II Neuropsychological Testing	X	2.7541	169.52	67.80	33.90
0384	GI Procedures with Stents	T	22.6777	1,395.84	292.31	279.17
0385	Level I Prosthetic Urological Procedures	S	79.3730	4,885.49		977.10
0386	Level II Prosthetic Urological Procedures	S	135.7295	8,354.29		1,670.86
0387	Level II Hysteroscopy	T	33.3029	2,049.83	655.55	409.97
0388	Discography	S	14.2706	878.37	289.72	175.67
0389	Level I Non-imaging Nuclear Medicine	S	1.4072	86.61	33.98	17.32
0390	Level I Endocrine Imaging	S	2.3732	146.07	58.42	29.21
0391	Level II Endocrine Imaging	S	2.7556	169.61	66.18	33.92
0392	Level II Non-imaging Nuclear Medicine	S	2.0849	128.33	51.33	25.67
0393	Red Cell/Plasma Studies	S	3.5902	220.98	82.04	44.20
0394	Hepatobiliary Imaging	S	4.4705	275.16	102.61	55.03
0395	GI Tract Imaging	S	3.6937	227.35	89.73	45.47
0396	Bone Imaging	S	4.0166	247.23	95.02	49.45
0397	Vascular Imaging	S	2.2521	138.62	49.58	27.72
0398	Level I Cardiac Imaging	S	4.2511	261.66	100.06	52.33
0399	Nuclear Medicine Add-on Imaging	S	1.5282	94.06	35.80	18.81
0400	Hematopoietic Imaging	S	3.9304	241.92	93.22	48.38
0401	Level I Pulmonary Imaging	S	3.2013	197.04	78.81	39.41
0402	Brain Imaging	S	4.8596	299.11	119.64	59.82
0403	CSF Imaging	S	3.4867	214.61	83.35	42.92
0404	Renal and Genitourinary Studies Level I	S	3.4235	210.72	84.28	42.14
0405	Renal and Genitourinary Studies Level II	S	4.1056	252.70	98.77	50.54
0406	Level I Tumor/Infection Imaging	S	3.9386	242.42	96.96	48.48
0407	Level I Radionuclide Therapy	S	3.1506	193.92	77.56	38.78
0408	Level II Tumor/Infection Imaging	S	4.9998	307.74		61.55
0409	Red Blood Cell Tests	X	0.1237	7.61	2.20	1.52
0411	Respiratory Procedures	S	0.3793	23.35		4.67
0412	IMRT Treatment Delivery	S	5.5021	338.66		67.73
0413	Level II Radionuclide Therapy	S	5.1026	314.07		62.81
0415	Level II Endoscopy Lower Airway	T	21.8803	1,346.75	459.92	269.35
0416	Level I Intravascular and Intracardiac Ultrasound and Flow Reserve	S	32.2182	1,983.06		396.61
0417	Computerized Reconstruction	S	3.1140	191.67		38.33
0418	Insertion of Left Ventricular Pacing Elect.	T	267.8870	16,488.71		3,297.74
0421	Prolonged Physiologic Monitoring	X	1.6486	101.47		20.29
0422	Level II Upper GI Procedures	T	27.5493	1,695.69	448.81	339.14
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	39.0235	2,401.94		480.39
0425	Level II Arthroplasty with Prosthesis	T	105.1666	6,473.11	1,378.01	1,294.62
0426	Level II Strapping and Cast Application	S	2.2728	139.89		27.98

ADDENDUM A.—OPPS PROPOSED LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
0427	Level III Tube Changes and Repositioning	T	11.5220	709.19		141.84
0428	Level III Sigmoidoscopy and Anoscopy	T	20.4902	1,261.19		252.24
0429	Level V Cystourethroscopy and other Genitourinary Procedures	T	42.9327	2,642.55		528.51
0432	Health and Behavior Services	S	0.6006	36.97		7.39
0433	Level II Pathology	X	0.2571	15.82	5.93	3.16
0434	Cardiac Defect Repair	T	87.3424	5,376.01		1,075.20
0436	Level I Drug Administration	S	0.1769	10.89		2.18
0437	Level II Drug Administration	S	0.4107	25.28		5.06
0438	Level III Drug Administration	S	0.7892	48.58		9.72
0439	Level IV Drug Administration	S	1.5841	97.50		19.50
0440	Level V Drug Administration	S	1.8285	112.55		22.51
0441	Level VI Drug Administration	S	2.5071	154.31		30.86
0442	Dosimetric Drug Administration	S	24.5410	1,510.52		302.10
0443	Overnight Pulse Oximetry	X	0.9939	61.18	24.47	12.24
0604	Level 1 Clinic Visits	V	0.8083	49.75		9.95
0605	Level 2 Clinic Visits	V	1.0057	61.90		12.38
0606	Level 3 Clinic Visits	V	1.3546	83.38		16.68
0607	Level 4 Clinic Visits	V	1.7080	105.13		21.03
0608	Level 5 Clinic Visits	V	2.1226	130.65		26.13
0609	Level 1 Type A Emergency Visits	V	0.8323	51.23		10.25
0613	Level 2 Type A Emergency Visits	V	1.3728	84.50		16.90
0614	Level 3 Type A Emergency Visits	V	2.1692	133.52		26.70
0615	Level 4 Type A Emergency Visits	V	3.4790	214.14		42.83
0616	Level 5 Type A Emergency Visits	V	5.3773	330.98		66.20
0617	Critical Care	S	8.0167	493.44		98.69
0621	Level I Vascular Access Procedures	T	8.7841	540.67		108.13
0622	Level II Vascular Access Procedures	T	22.6984	1,397.11		279.42
0623	Level III Vascular Access Procedures	T	28.4646	1,752.02		350.40
0624	Minor Vascular Access Device Procedures	X	0.5336	32.84	13.13	6.57
0648	Breast Reconstruction with Prosthesis	T	48.7796	3,002.43		600.49
0651	Complex Interstitial Radiation Source Application	S	16.6585	1,025.35		205.07
0652	Insertion of Intraperitoneal and Pleural Catheters	T	29.2259	1,798.88		359.78
0653	Vascular Reconstruction/Fistula Repair with Device	T	31.0004	1,908.11		381.62
0654	Insertion/Replacement of a permanent dual chamber pacemaker	T	112.2347	6,908.16		1,381.63
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	153.1524	9,426.68		1,885.34
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	106.8902	6,579.20		1,315.84
0657	Placement of Tissue Clips	S	1.7625	108.48		21.70
0658	Percutaneous Breast Biopsies	T	6.4482	396.89		79.38
0659	Hyperbaric Oxygen	S	1.5925	98.02		19.60
0660	Level II Otorhinolaryngologic Function Tests	X	1.4988	92.25	29.07	18.45
0661	Level V Pathology	X	2.6066	160.44	64.17	32.09
0662	CT Angiography	S	4.9203	302.85	118.88	60.57
0663	Level I Electronic Analysis of Neurostimulator Pulse Generators	S	1.0752	66.18	16.96	13.24
0664	Level I Proton Beam Radiation Therapy	S	18.4698	1,136.83		227.37
0665	Bone Density:AppendicularSkeleton	S	0.5569	34.28		6.86
0667	Level II Proton Beam Radiation Therapy	S	22.0972	1,360.10		272.02
0668	Level I Angiography and Venography	S	6.3684	391.98	88.26	78.40
0670	Level II Intravascular and Intracardiac Ultrasound and Flow Reserve	S	29.7322	1,830.05	536.10	366.01
0672	Level IV Posterior Segment Eye Procedures	T	36.8820	2,270.12		454.02
0673	Level IV Anterior Segment Eye Procedures	T	37.3057	2,296.20	649.56	459.24
0674	Prostate Cryoablation	T	107.8298	6,637.03		1,327.41
0675	Prostatic Thermotherapy	T	42.3176	2,604.69		520.94
0676	Thrombolysis and Thrombectomy	T	2.0612	126.87		25.37
0678	External Counterpulsation	T	1.7263	106.26		21.25
0679	Level II Resuscitation and Cardioversion	S	5.5435	341.21	95.30	68.24
0680	Insertion of Patient Activated Event Recorders	S	74.8877	4,609.41		921.88
0681	Knee Arthroplasty	T	173.0706	10,652.67		2,130.53
0682	Level V Debridement & Destruction	T	6.7529	415.65	158.65	83.13
0683	Level II Photochemotherapy	S	2.6902	165.58		33.12
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	6.0729	373.79	115.47	74.76
0686	Level III Skin Repair	T	13.3433	821.29		164.26
0687	Revision/Removal of Neurostimulator Electrodes	T	17.1830	1,057.63	423.05	211.53
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver	T	33.9521	2,089.79	835.91	417.96
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5400	33.24		6.65
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.3628	22.33	8.67	4.47
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.8253	173.90	60.61	34.78
0692	Level II Electronic Analysis of Neurostimulator Pulse Generators	S	1.9519	120.14	30.16	24.03
0693	Breast Reconstruction	T	37.4843	2,307.20	731.74	461.44

ADDENDUM A.—OPPS PROPOSED LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
0694	Mohs Surgery	T	3.4844	214.47	58.14	42.89
0695	Level VII Debridement & Destruction	T	20.5802	1,266.73	266.59	253.35
0697	Level I Echocardiogram Except Transesophageal	S	1.6002	98.49	35.99	19.70
0698	Level II Eye Tests & Treatments	S	1.2244	75.36	16.52	15.07
0699	Level IV Eye Tests & Treatments	T	13.9509	858.69		171.74
0700	Antepartum Manipulation	T	2.8011	172.41		34.48
0701	Sr89 strontium	K		533.58		106.72
0702	Sm 153 lexidronm	K		1,316.41		263.28
0704	In111 satumomab	K		192.12		38.42
0705	Tc99m tetrofosmin	K		73.81		14.76
0722	Tc99m pentetate	K		56.77		11.35
0723	Co57/58	K		149.44		29.89
0724	Co57 cyano	K		63.74		12.75
0726	Dexrazoxane HCl injection	K		179.62		35.92
0728	Filgrastim 300 mcg injection	K		182.53		36.51
0730	Pamidronate disodium /30 MG	K		29.31		5.86
0731	Sargramostim injection	K		23.12		4.62
0732	Mesna injection	K		7.87		1.57
0735	Ampho b cholesteryl sulfate	K		12.00		2.40
0736	Amphotericin b liposome inj	K		17.40		3.48
0737	Nitrogen N–13 ammonia	K		230.77		46.15
0738	Rasburicase	K		110.36		22.07
0739	Tc99m depreotide	K		67.91		13.58
0740	Tc99m gluceptate	K		236.53		47.31
0741	Cr51 chromate	K		167.62		33.52
0742	Tc99m labeled rbc	K		132.95		26.59
0743	Tc99m mertiatide	K		180.08		36.02
0744	Plague vaccine, im	K		150.00		30.00
0750	Dolasetron mesylate	K		6.76		1.35
0763	Dolasetron mesylate oral	K		47.52		9.50
0764	Granisetron HCl injection	K		6.80		1.36
0765	Granisetron HCl 1 mg oral	K		37.08		7.42
0768	Ondansetron hcl injection	K		3.69		0.74
0769	Ondansetron HCl 8mg oral	K		34.21		6.84
0800	Leuprolide acetate /3.75 MG	K		440.36		88.07
0802	Etoposide oral 50 MG	K		32.73		6.55
0807	Aldesleukin/single use vial	K		734.10		146.82
0809	Bcg live intravesical vac	K		110.48		22.10
0810	Goserelin acetate implant	K		197.59		39.52
0811	Carboplatin injection	K		13.74		2.75
0812	Carmus bischl nitro inj	K		139.66		27.93
0814	Asparaginase injection	K		53.66		10.73
0820	Daunorubicin	K		23.36		4.67
0821	Daunorubicin citrate liposom	K		55.72		11.14
0823	Docetaxel	K		294.48		58.90
0827	Floxuridine injection	K		62.61		12.52
0828	Gemcitabine HCl	K		116.59		23.32
0830	Irinotecan injection	K		125.28		25.06
0831	Ifosfomide injection	K		54.19		10.84
0832	Idarubicin hcl injection	K		265.53		53.11
0834	Interferon alfa-2a inj	K		33.53		6.71
0835	Inj cosyntropin per 0.25 MG	K		63.55		12.71
0836	Interferon alfa-2b inj	K		13.54		2.71
0838	Interferon gamma 1–b inj	K		289.87		57.97
0840	Inj melphalan hydrochl 50 MG	K		1,190.81		238.16
0842	Fludarabine phosphate inj	K		230.11		46.02
0843	Pegaspargase/singl dose vial	K		1,596.00		319.20
0844	Pentostatin injection	K		2,000.96		400.19
0849	Rituximab cancer treatment	K		465.23		93.05
0850	Streptozocin injection	K		147.45		29.49
0851	Thiotepa injection	K		45.38		9.08
0852	Topotecan	K		780.54		156.11
0855	Vinorelbine tartrate/10 mg	K		22.04		4.41
0856	Porfimer sodium	K		2,481.76		496.35
0858	Inj cladribine per 1 MG	K		38.28		7.66
0860	Plicamycin (mithramycin) inj	K		173.66		34.73
0861	Leuprolide acetate injeciton	K		7.86		1.57
0862	Mitomycin 5 MG inj	K		18.82		3.76
0863	Paclitaxel injection	K		15.44		3.09

ADDENDUM A.—OPPS PROPOSED LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
0864	Mitoxantrone hydrochl / 5 MG	K		336.76		67.35
0865	Interferon alfa-n3 inj	K		50.33		10.07
0868	Oral aprepitant	G		4.63		0.93
0876	Caffeine citrate injection	K		3.34		0.67
0884	Rho d immune globulin inj	K		97.11		19.42
0887	Azathioprine parenteral	K		48.73		9.75
0888	Cyclosporine oral 100 mg	K		3.88		0.78
0890	Lymphocyte immune globulin	K		295.38		59.08
0891	Tacrolimus oral per 1 MG	K		3.40		0.68
0892	Edetate calcium disodium inj	K		39.80		7.96
0895	Deferoxamine mesylate inj	K		14.77		2.95
0900	Alglucerase injection	K		38.85		7.77
0901	Alpha 1 proteinase inhibitor	K		3.21		0.64
0902	Botulinum toxin a per unit	K		4.85		0.97
0903	Cytomegalovirus imm IV /vial	K		755.79		151.16
0906	RSV-ivig	K		16.02		3.20
0910	Interferon beta-1b / .25 MG	K		91.34		18.27
0911	Inj streptokinase /250000 IU	K		78.75		15.75
0912	Interferon alfacon-1	K		3.92		0.78
0913	Ganciclovir long act implant	K		4,200.00		840.00
0916	Injection imiglucerase /unit	K		3.87		0.77
0917	Adenosine injection	K		69.41		13.88
0925	Factor viii	K		0.68		0.14
0926	Factor VIII (porcine)	K		0.66		0.13
0927	Factor viii recombinant	K		1.05		0.21
0928	Factor ix complex	K		0.63		0.13
0929	Anti-inhibitor	K		1.29		0.26
0930	Antithrombin iii injection	K		1.62		0.32
0931	Factor IX non-recombinant	K		0.88		0.18
0932	Factor IX recombinant	K		0.98		0.20
0935	Clonidine hydrochloride	K		62.71		12.54
0949	Frozen plasma, pooled, sd	K	0.9060	55.77		11.15
0950	Whole blood for transfusion	K	2.1824	134.33		26.87
0952	Cryoprecipitate each unit	K	0.8571	52.76		10.55
0954	RBC leukocytes reduced	K	2.8738	176.89		35.38
0955	Plasma, frz between 8–24 hour	K	1.1864	73.02		14.60
0956	Plasma protein fract,5%,50ml	K	0.4016	24.72		4.94
0957	Platelets, each unit	K	0.9794	60.28		12.06
0958	Plaelet rich plasma unit	K	2.5336	155.95		31.19
0959	Red blood cells unit	K	2.1045	129.53		25.91
0960	Washed red blood cells unit	K	3.5028	215.60		43.12
0961	Albumin (human),5%, 50ml	K		25.48		5.10
0963	Albumin (human), 5%, 250 ml	K		72.09		14.42
0964	Albumin (human), 25%, 20 ml	K		26.79		5.36
0965	Albumin (human), 25%, 50ml	K		61.77		12.35
0966	Plasmaprotein fract,5%,250ml	K	3.1309	192.71		38.54
0967	Blood split unit	K	2.2087	135.95		27.19
0968	Platelets leukoreduced irrad	K	2.1192	130.44		26.09
0969	RBC leukoreduced irradiated	K	3.7037	227.97		45.59
1009	Cryoprecipitatereducedplasma	K	1.2990	79.95		15.99
1010	Blood, l/r, cmv-neg	K	2.1991	135.36		27.07
1011	Platelets, hla-m, l/r, unit	K	10.5084	646.80		129.36
1013	Platelets leukocytes reduced	K	1.5318	94.28		18.86
1016	Blood, l/r, froz/degly/wash	K	1.4462	89.02		17.80
1017	Plt, aph/pher, l/r, cmv-neg	K	6.1508	378.59		75.72
1018	Blood, l/r, irradiated	K	2.1765	133.97		26.79
1019	Plate pheres leukoredu irrad	K	9.9841	614.53		122.91
1020	Plt, pher, l/r cmv-neg, irr	K	11.7025	720.30		144.06
1021	RBC, frz/deg/wsh, l/r, irrad	K	6.9189	425.87		85.17
1022	RBC, l/r, cmv-neg, irrad	K	4.2818	263.55		52.71
1045	I131 iodobenguate, dx	K		429.55		85.91
1052	Injection, voriconazole	K		4.55		0.91
1064	Th I131 so iodide cap millic	K		14.54		2.91
1083	Adalimumab injection	K		304.40		60.88
1084	Denileukin diftitox, 300 mcg	K		1,391.05		278.21
1086	Temozolomide	K		7.16		1.43
1088	Iodine I–131 iodide cap, dx	K		24.86		4.97
1096	Tc99m exametazime	K		317.07		63.41
1150	I131 iodide sol, rx	K		12.60		2.52

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APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
1166	Cytarabine liposome	K		374.75		74.95
1167	Inj, epirubicin hcl, 2 mg	K		24.47		4.89
1178	BUSULFAN IV, 6 Mg	K		24.87		4.97
1203	Verteporfin injection	K		8.89		1.78
1207	Octreotide injection, depot	K		89.50		17.90
1280	Corticotropin injection	K		108.85		21.77
1330	Ergonovine maleate injection	K		27.56		5.51
1436	Etidronate disodium inj	K		70.73		14.15
1491	New Technology—Level IA ($0–$10)	S		5.00		1.00
1492	New Technology—Level IB ($10–$20)	S		15.00		3.00
1493	New Technology—Level IC ($20–$30)	S		25.00		5.00
1494	New Technology—Level ID ($30–$40)	S		35.00		7.00
1495	New Technology—Level IE ($40–$50)	S		45.00		9.00
1496	New Technology—Level IA ($0–$10)	T		5.00		1.00
1497	New Technology—Level IB($10–$20)	T		15.00		3.00
1498	New Technology—Level IC ($20–$30)	T		25.00		5.00
1499	New Technology—Level ID($30–$40)	T		35.00		7.00
1500	New Technology—Level IE ($40–$50)	T		45.00		9.00
1502	New Technology—Level II ($50–$100)	S		75.00		15.00
1503	New Technology—Level III ($100–$200)	S		150.00		30.00
1504	New Technology—Level IV ($200–$300)	S		250.00		50.00
1505	New Technology—Level V ($300–$400)	S		350.00		70.00
1506	New Technology—Level VI ($400–$500)	S		450.00		90.00
1507	New Technology—Level VII ($500–$600)	S		550.00		110.00
1508	New Technology—Level VIII ($600–$700)	S		650.00		130.00
1509	New Technology—Level IX ($700–$800)	S		750.00		150.00
1510	New Technology—Level X ($800–$900)	S		850.00		170.00
1511	New Technology—Level XI ($900–$1000)	S		950.00		190.00
1512	New Technology—Level XII ($1000–$1100)	S		1,050.00		210.00
1513	New Technology—Level XIII ($1100–$1200)	S		1,150.00		230.00
1514	New Technology—Level XIV ($1200–$1300)	S		1,250.00		250.00
1515	New Technology—Level XV ($1300–$1400)	S		1,350.00		270.00
1516	New Technology—Level XVI ($1400–$1500)	S		1,450.00		290.00
1517	New Technology—Level XVII ($1500–$1600)	S		1,550.00		310.00
1518	New Technology—Level XVIII ($1600–$1700)	S		1,650.00		330.00
1519	New Technology—Level IXX ($1700–$1800)	S		1,750.00		350.00
1520	New Technology—Level XX ($1800–$1900)	S		1,850.00		370.00
1521	New Technology—Level XXI ($1900–$2000)	S		1,950.00		390.00
1522	New Technology—Level XXII ($2000–$2500)	S		2,250.00		450.00
1523	New Technology—Level XXIII ($2500–$3000)	S		2,750.00		550.00
1524	New Technology—Level XIV ($3000–$3500)	S		3,250.00		650.00
1525	New Technology—Level XXV ($3500–$4000)	S		3,750.00		750.00
1526	New Technology—Level XXVI ($4000–$4500)	S		4,250.00		850.00
1527	New Technology—Level XXVII ($4500–$5000)	S		4,750.00		950.00
1528	New Technology—Level XXVIII ($5000–$5500)	S		5,250.00		1,050.00
1529	New Technology—Level XXIX ($5500–$6000)	S		5,750.00		1,150.00
1530	New Technology—Level XXX ($6000–$6500)	S		6,250.00		1,250.00
1531	New Technology—Level XXXI ($6500–$7000)	S		6,750.00		1,350.00
1532	New Technology—Level XXXII ($7000–$7500)	S		7,250.00		1,450.00
1533	New Technology—Level XXXIII ($7500–$8000)	S		7,750.00		1,550.00
1534	New Technology—Level XXXIV ($8000–$8500)	S		8,250.00		1,650.00
1535	New Technology—Level XXXV ($8500–$9000)	S		8,750.00		1,750.00
1536	New Technology—Level XXXVI ($9000–$9500)	S		9,250.00		1,850.00
1537	New Technology—Level XXXVII ($9500–$10000)	S		9,750.00		1,950.00
1539	New Technology—Level II ($50–$100)	T		75.00		15.00
1540	New Technology—Level III ($100–$200)	T		150.00		30.00
1541	New Technology—Level IV ($200–$300)	T		250.00		50.00
1542	New Technology—Level V ($300–$400)	T		350.00		70.00
1543	New Technology—Level VI ($400–$500)	T		450.00		90.00
1544	New Technology—Level VII ($500—$600)	T		550.00		110.00
1545	New Technology—Level VIII ($600–$700)	T		650.00		130.00
1546	New Technology—Level IX ($700–$800)	T		750.00		150.00
1547	New Technology—Level X ($800–$900)	T		850.00		170.00
1548	New Technology—Level XI ($900–$1000)	T		950.00		190.00
1549	New Technology—Level XII ($1000–$1100)	T		1,050.00		210.00
1550	New Technology—Level XIII ($1100–$1200)	T		1,150.00		230.00
1551	New Technology—Level XIV ($1200–$1300)	T		1,250.00		250.00
1552	New Technology—Level XV ($1300–$1400)	T		1,350.00		270.00
1553	New Technology—Level XVI ($1400–$1500)	T		1,450.00		290.00

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APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
1554	New Technology—Level XVII ($1500–$1600)	T		1,550.00		310.00
1555	New Technology—Level XVIII ($1600–$1700)	T		1,650.00		330.00
1556	New Technology—Level XIX ($1700–$1800)	T		1,750.00		350.00
1557	New Technology—Level XX ($1800–$1900)	T		1,850.00		370.00
1558	New Technology—Level XXI ($1900–$2000)	T		1,950.00		390.00
1559	New Technology—Level XXII ($2000–$2500)	T		2,250.00		450.00
1560	New Technology—Level XXIII ($2500–$3000)	T		2,750.00		550.00
1561	New Technology—Level XXIV ($3000–$3500)	T		3,250.00		650.00
1562	New Technology—Level XXV ($3500–$4000)	T		3,750.00		750.00
1563	New Technology—Level XXVI ($4000–$4500)	T		4,250.00		850.00
1564	New Technology—Level XXVII ($4500–$5000)	T		4,750.00		950.00
1565	New Technology—Level XXVIII ($5000–$5500)	T		5,250.00		1,050.00
1566	New Technology—Level XXIX ($5500–$6000)	T		5,750.00		1,150.00
1567	New Technology—Level XXX ($6000–$6500)	T		6,250.00		1,250.00
1568	New Technology—Level XXXI ($6500–$7000)	T		6,750.00		1,350.00
1569	New Technology—Level XXXII ($7000–$7500)	T		7,250.00		1,450.00
1570	New Technology—Level XXXIII ($7500–$8000)	T		7,750.00		1,550.00
1571	New Technology—Level XXXIV ($8000–$8500)	T		8,250.00		1,650.00
1572	New Technology—Level XXXV ($8500–$9000)	T		8,750.00		1,750.00
1573	New Technology—Level XXXVI ($9000–$9500)	T		9,250.00		1,850.00
1574	New Technology—Level XXXVII ($9500–$10000)	T		9,750.00		1,950.00
1600	Tc99m sestamibi	K		82.58		16.52
1603	TL201 thallium	K		27.18		5.44
1604	In111 capromab	K		928.19		185.64
1605	Abciximab injection	K		452.96		90.59
1606	Injection anistreplase 30 u	K		2,265.46		453.09
1607	Eptifibatide injection	K		13.31		2.66
1608	Etanercept injection	K		154.12		30.82
1609	Rho(D) immune globulin h, sd	K		13.57		2.71
1611	Hylan G–F 20 injection	K		196.99		39.40
1612	Daclizumab, parenteral	K		345.07		69.01
1613	Trastuzumab	K		54.59		10.92
1629	Nonmetabolic act d/e tissue	K		15.20		3.04
1630	Hep b ig, im	K		118.61		23.72
1631	Baclofen intrathecal trial	K		70.20		14.04
1632	Metabolic active D/E tissue	K		27.56		5.51
1633	Alefacept	K		26.03		5.21
1642	In111 ibritumomab, dx	K		1,344.34		268.87
1643	Y90 ibritumomab, rx	K		12,130.20		2,426.04
1644	I131 tositumomab, dx	K		1,368.17		273.63
1645	I131 tositumomab, rx	K		11,868.78		2,373.76
1646	In111 oxyquinoline	K		306.51		61.30
1647	In111 pentetate	K		262.81		52.56
1648	Tc99m arcitumomab	K		255.95		51.19
1650	Tc99m succimer	K		84.79		16.96
1651	F18 fdg	K		235.56		47.11
1654	Rb82 rubidium	K		239.83		47.97
1655	Tinzaparin sodium injection	K		2.18		0.44
1670	Tetanus immune globulin inj	K		90.71		18.14
1671	Ga67 gallium	K		22.73		4.55
1672	Tc99m bicisate	K		254.46		50.89
1675	P32 Na phosphate	K		117.11		23.42
1676	P32 chromic phosphate	K		222.35		44.47
1677	In111 pentetreotide	K		185.60		37.12
1678	Tc99m fanolesomab	K		527.31		105.46
1680	Acetylcysteine injection	K		1.86		0.37
1682	Aprotonin, 10,000 kiu	K		2.32		0.46
1683	Basiliximab	K		1,388.81		277.76
1684	Corticorelin ovine triflutal	K		4.22		0.84
1685	Darbepoetin alfa, non-esrd	K		3.00		0.60
1686	Epoetin alfa, non-esrd	K		9.25		1.85
1687	Digoxin immune fab (ovine)	K		527.46		105.49
1688	Ethanolamine oleate	K		71.57		14.31
1689	Fomepizole	K		11.82		2.36
1690	Hemin	K		6.59		1.32
1691	Iron dextran 165 injection	K		12.30		2.46
1692	Iron dextran 267 injection	K		10.17		2.03
1693	Lepirudin	K		146.38		29.28
1694	Ziconotide injection	G		6.20		1.24

ADDENDUM A.—OPPS PROPOSED LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
1695	Nesiritide injection	K		29.72		5.94
1696	Palifermin injection	K		11.37		2.27
1697	Pegaptanib sodium injection	G		1,107.54		221.51
1700	Inj secretin synthetic human	K		20.31		4.06
1701	Treprostinil injection	K		53.51		10.70
1703	Ovine, 1000 USP units	K		133.77		26.75
1704	Inj Vonwillebrand factor iu	K		0.87		0.17
1705	Factor viia	K		1.08		0.22
1707	Non-human, metabolic tissue	K		1.64		0.33
1709	Azacitidine injection	K		4.09		0.82
1710	Clofarabine injection	G		116.68		23.34
1711	Histrelin implant	K		2,019.82		403.96
1712	Paclitaxel injection	G		8.73		1.75
1713	Inj Fe-based MR contrast,1ml	K		30.12		6.02
1716	Brachytx source, Gold 198	K	0.4493	27.65		5.53
1717	Brachytx source, HDR Ir–192	K	2.1922	134.93		26.99
1718	Brachytx source, Iodine 125	K	0.5754	35.42		7.08
1719	Brachytx sour, Non-HDR Ir–192	K	0.5108	31.44		6.29
1720	Brachytx sour, Palladium 103	K	0.7945	48.90		9.78
1738	Oxaliplatin	K		8.47		1.69
1739	Pegademase bovine, 25 iu	K		164.50		32.90
1740	Diazoxide injection	K		110.88		22.18
1741	Urofollitropin, 75 iu	K		48.84		9.77
1820	Generator neuro rechg bat sys	H				
2210	Methyldopate hcl injection	K		9.86		1.97
2616	Brachytx source, Yttrium-90	K	272.7710	16,789.33		3,357.87
2632	Brachytx sol, I–125, per mCi	K	0.3139	19.32		3.86
2633	Brachytx source, Cesium-131	K	1.4622	90.00		18.00
2634	Brachytx source, HA, I–125	K	0.4172	25.68		5.14
2635	Brachytx source, HA, P–103	K	0.8820	54.29		10.86
2636	Brachytx linear source, P–103	K	0.6360	39.15		7.83
2637	Brachytx, Ytterbium-169	K	0.4172	25.68		5.14
2731	Immune globulin, powder	K		22.05		4.41
2732	Immune globulin, liquid	K		28.82		5.76
2770	Quinupristin/dalfopristin	K		108.03		21.61
2940	Somatrem injection	K		583.74		116.75
3030	Sumatriptan succinate / 6 MG	K		51.75		10.35
3032	Dtp/hib vaccine, im	K		68.91		13.78
3038	Inj biperiden lactate/5 mg	K		88.36		17.67
3039	Inj metaraminol bitartrate	K		17.68		3.54
3040	Penicillin g benzathine inj	K		67.86		13.57
3041	Bivalirudin	K		1.62		0.32
3042	Foscarnet sodium injection	K		10.69		2.14
3043	Gamma globulin 1 CC inj	K		10.59		2.12
3045	Meropenem	K		3.76		0.75
3046	Octreotide inj, non-depot	K		4.34		0.87
3047	Melphalan oral 2 MG	K		4.39		0.88
3048	Doxorubic hcl 10 MG vl chemo	K		6.23		1.25
3049	Cyclophosphamide lyophilized	K		5.47		1.09
3050	Sermorelin acetate injection	K		1.73		0.35
7000	Amifostine	K		448.41		89.68
7005	Gonadorelin hydroch/ 100 mcg	K		178.59		35.72
7011	Oprelvekin injection	K		243.39		48.68
7015	Oral busulfan	K		1.95		0.39
7028	Fosphenytoin, 50 mg	K		5.18		1.04
7034	Somatropin injection	K		43.73		8.75
7035	Teniposide, 50 mg	K		264.26		52.85
7036	Urokinase 250,000 IU inj	K		453.41		90.68
7038	Monoclonal antibodies	K		860.94		172.19
7041	Tirofiban HCl	K		7.61		1.52
7042	Capecitabine, oral, 150 mg	K		3.60		0.72
7043	Infliximab injection	K		53.73		10.75
7045	Inj trimetrexate glucoronate	K		144.39		28.88
7046	Doxorubicin hcl liposome inj	K		367.56		73.51
7048	Alteplase recombinant	K		31.06		6.21
7049	Filgrastim 480 mcg injection	K		289.59		57.92
7051	Leuprolide acetate implant	K		2,157.81		431.56
7308	Aminolevulinic acid hcl top	K		99.92		19.98
7316	Sodium hyaluronate injection	K		112.04		22.41

ADDENDUM A.—OPPS PROPOSED LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
9001	Linezolid injection	K		23.50		4.70
9002	Tenecteplase injection	K		2,059.01		411.80
9003	Palivizumab, per 50 mg	K		609.62		121.92
9004	Gemtuzumab ozogamicin	K		2,265.57		453.11
9005	Reteplase injection	K		754.71		150.94
9006	Tacrolimus injection	K		135.17		27.03
9012	Arsenic trioxide	K		32.92		6.58
9015	Mycophenolate mofetil oral	K		2.50		0.50
9018	Botulinum toxin type B	K		7.85		1.57
9019	Caspofungin acetate	K		32.19		6.44
9020	Sirolimus, oral	K		6.84		1.37
9022	IM inj interferon beta 1–a	K		97.99		19.60
9023	Rho d immune globulin 50 mcg	K		14.13		2.83
9024	Amphotericin b lipid complex	K		11.10		2.22
9031	Arbutamine HCl injection	K		160.00		32.00
9032	Baclofen 10 MG injection	K		191.50		38.30
9033	Cidofovir injection	K		757.03		151.41
9038	Inj estrogen conjugate 25 MG	K		57.78		11.56
9040	Intraocular Fomivirsen na	K		210.00		42.00
9042	Glucagon hydrochloride/1 MG	K		62.42		12.48
9044	Ibutilide fumarate injection	K		249.01		49.80
9046	Iron sucrose injection	K		0.36		0.07
9047	Itraconazole injection	K		36.23		7.25
9051	Urea injection	K		69.10		13.82
9054	Metabolically active tissue	K		15.01		3.00
9100	I131 serum albumin, dx	K		36.78		7.36
9104	Antithymocyte globuln rabbit	K		301.48		60.30
9108	Thyrotropin injection	K		766.61		153.32
9110	Alemtuzumab injection	K		525.75		105.15
9112	Inj perflutren lip micros,ml	K		61.25		12.25
9115	Zoledronic acid	K		200.82		40.16
9119	Injection, pegfilgrastim 6mg	K		2,142.79		428.56
9120	Injection, Fulvestrant	K		80.31		16.06
9121	Injection, argatroban	K		16.40		3.28
9122	Triptorelin pamoate	K		300.90		60.18
9124	Daptomycin injection	K		0.31		0.06
9125	Risperidone, long acting	K		4.73		0.95
9126	Natalizumab injection	G		6.39		1.28
9133	Rabies ig, im/sc	K		63.98		12.80
9134	Rabies ig, heat treated	K		68.58		13.72
9135	Varicella-zoster ig, im	K		149.08		29.82
9137	Bcg vaccine, percut	K		115.46		23.09
9139	Rabies vaccine, im	K		155.25		31.05
9140	Rabies vaccine, id	K		118.49		23.70
9141	Measles-rubella vaccine, sc	K		44.62		8.92
9142	Chicken pox vaccine, sc	K		66.84		13.37
9143	Meningococcal vaccine, sc	K		84.46		16.89
9144	Encephalitis vaccine, sc	K		99.15		19.83
9145	Meningococcal vaccine, im	K		143.12		28.62
9148	I123 iodide cap, dx	K		27.44		5.49
9156	Nonmetabolic active tissue	K		66.39		13.28
9157	LOCM < = 149 mg/ml iodine, 1ml	K		0.30		0.06
9158	LOCM 150–199mg/ml iodine,1ml	K		1.84		0.37
9159	LOCM 200–249mg/ml iodine,1ml	K		1.25		0.25
9160	LOCM 250–299mg/ml iodine,1ml	K		0.32		0.06
9161	LOCM 300–349mg/ml iodine,1ml	K		0.34		0.07
9162	LOCM 350–399mg/ml iodine,1ml	K		0.21		0.04
9163	LOCM > = 400 mg/ml iodine,1ml	K		0.30		0.06
9164	Inj Gad-base MR contrast,1ml	K		2.88		0.58
9165	Oral MR contrast	K		8.87		1.77
9167	Valrubicin	K		76.03		15.21
9202	Inj octafluoropropane mic,ml	K		40.75		8.15
9203	Inj perflexane lip micros,ml	K		8.22		1.64
9207	Bortezomib injection	K		29.81		5.96
9208	Agalsidase beta injection	K		126.00		25.20
9209	Laronidase injection	K		23.64		4.73
9210	Palonosetron HCl	K		17.51		3.50
9213	Pemetrexed injection	K		40.90		8.18
9214	Bevacizumab injection	K		56.36		11.27

ADDENDUM A.—OPPS PROPOSED LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS (SI), RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2007—Continued

APC	Group title	SI	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copyment
9215	Cetuximab injection	K		49.39		9.88
9216	Abarelix injection	K		66.20		13.24
9217	Leuprolide acetate suspnsion	K		242.99		48.60
9219	Mycophenolic acid	K		2.15		0.43
9220	Sodium hyaluronate	K		197.62		39.52
9222	Graftjacket SftTis	K		883.78		176.76
9224	Injection, galsulfase	K		1,503.23		300.65
9225	Fluocinolone acetonide	G		19,345.00		3,869.00
9227	Injection, micafungin sodium	G		1.98		0.40
9228	Injection, tigecycline	G		0.96		0.19
9300	Omalizumab injection	K		16.34		3.27
9500	Platelets, irradiated	K	2.0957	128.99		25.80
9501	Platelet pheres leukoreduced	K	7.9414	488.80		97.76
9502	Platelet pheresis irradiated	K	6.6959	412.14		82.43
9503	Fr frz plasma donor retested	K	1.1915	73.34		14.67
9504	RBC deglycerolized	K	5.7106	351.49		70.30
9505	RBC irradiated	K	3.2600	200.66		40.13
9506	Granulocytes, pheresis unit	K	4.1030	252.54		50.51
9507	Platelets, pheresis	K	7.5381	463.98		92.80
9508	Plasma 1 donor frz w/in 8 hr	K	1.1677	71.87		14.37

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
10121	Remove foreign body	2	$920.58	$446.00		$89.20
10180	Complex drainage, wound	2	$1,075.21	$446.00		$89.20
11010	Debride skin, fx	2	$246.96	$246.96	Y	$49.39
11011	Debride skin/muscle, fx	2	$246.96	$246.96	Y	$49.39
11012	Debride skin/muscle/bone, fx	2	$246.96	$246.96	Y	$49.39
11042	Debride skin/tissue	2	$161.59	$161.59	Y	$32.32
11043	Debride tissue/muscle	2	$161.59	$161.59	Y	$32.32
11044	Debride tissue/muscle/bone	2	$415.65	$415.65	Y	$83.13
11404	Exc tr-ext b9+marg 3.1–4 cm	1	$920.58	$333.00		$66.60
11406	Exc tr-ext b9+marg > 4.0 cm	2	$920.58	$446.00		$89.20
11424	Exc h-f-nk-sp b9+marg 3.1–4	2	$920.58	$446.00		$89.20
11426	Exc h-f-nk-sp b9+marg > 4 cm	2	$1,229.54	$446.00		$89.20
11444	Exc face-mm b9+marg 3.1–4 cm	1	$400.87	$333.00		$66.60
11446	Exc face-mm b9+marg > 4 cm	2	$1,229.54	$446.00		$89.20
11450	Removal, sweat gland lesion	2	$1,229.54	$446.00		$89.20
11451	Removal, sweat gland lesion	2	$1,229.54	$446.00		$89.20
11462	Removal, sweat gland lesion	2	$1,229.54	$446.00		$89.20
11463	Removal, sweat gland lesion	2	$1,229.54	$446.00		$89.20
11470	Removal, sweat gland lesion	2	$1,229.54	$446.00		$89.20
11471	Removal, sweat gland lesion	2	$1,229.54	$446.00		$89.20
11604	Exc tr-ext mlg+marg 3.1–4 cm	2	$400.87	$400.87	Y	$80.17
11606	Exc tr-ext mlg+marg > 4 cm	2	$920.58	$446.00		$89.20
11624	Exc h-f-nk-sp mlg+marg 3.1–4	2	$920.58	$446.00		$89.20
11626	Exc h-f-nk-sp mlg+mar > 4 cm	2	$1,229.54	$446.00		$89.20
11644	Exc face-mm malig+marg 3.1–4	2	$920.58	$446.00		$89.20
11646	Exc face-mm mlg+marg > 4 cm	2	$1,229.54	$446.00		$89.20
11770	Removal of pilonidal lesion	3	$1,229.54	$510.00		$102.00
11771	Removal of pilonidal lesion	3	$1,229.54	$510.00		$102.00
11772	Removal of pilonidal lesion	3	$1,229.54	$510.00		$102.00
11960	Insert tissue expander(s)	2	$1,308.85	$446.00		$89.20
11970	Replace tissue expander	3	$2,539.24	$510.00		$102.00
11971	Remove tissue expander(s)	1	$1,229.54	$333.00		$66.60
12005	Repair superficial wound(s)	2	$91.86	$91.86	Y	$18.37
12006	Repair superficial wound(s)	2	$91.86	$91.86	Y	$18.37
12007	Repair superficial wound(s)	2	$91.86	$91.86	Y	$18.37
12016	Repair superficial wound(s)	2	$91.86	$91.86	Y	$18.37
12017	Repair superficial wound(s)	2	$91.86	$91.86	Y	$18.37
12018	Repair superficial wound(s)	2	$91.86	$91.86	Y	$18.37
12020	Closure of split wound	1	$91.86	$91.86	Y	$18.37
12021	Closure of split wound	1	$91.86	$91.86	Y	$18.37

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
12034	Layer closure of wound(s)	2	$91.86	$91.86	Y	$18.37
12035	Layer closure of wound(s)	2	$91.86	$91.86	Y	$18.37
12036	Layer closure of wound(s)	2	$91.86	$91.86	Y	$18.37
12037	Layer closure of wound(s)	2	$313.49	$313.49	Y	$62.70
12044	Layer closure of wound(s)	2	$91.86	$91.86	Y	$18.37
12045	Layer closure of wound(s)	2	$91.86	$91.86	Y	$18.37
12046	Layer closure of wound(s)	2	$91.86	$91.86	Y	$18.37
12047	Layer closure of wound(s)	2	$313.49	$313.49	Y	$62.70
12054	Layer closure of wound(s)	2	$91.86	$91.86	Y	$18.37
12055	Layer closure of wound(s)	2	$91.86	$91.86	Y	$18.37
12056	Layer closure of wound(s)	2	$91.86	$91.86	Y	$18.37
12057	Layer closure of wound(s)	2	$313.49	$313.49	Y	$62.70
13100	Repair of wound or lesion	2	$313.49	$313.49	Y	$62.70
13101	Repair of wound or lesion	3	$313.49	$313.49	Y	$62.70
13102	Repair wound/lesion add-on	1	$91.86	$91.86	Y	$18.37
13120	Repair of wound or lesion	2	$91.86	$91.86	Y	$18.37
13121	Repair of wound or lesion	3	$91.86	$91.86	Y	$18.37
13122	Repair wound/lesion add-on	1	$91.86	$91.86	Y	$18.37
13131	Repair of wound or lesion	2	$91.86	$91.86	Y	$18.37
13132	Repair of wound or lesion	3	$91.86	$91.86	Y	$18.37
13133	Repair wound/lesion add-on	1	$91.86	$91.86	Y	$18.37
13150	Repair of wound or lesion	3	$313.49	$313.49	Y	$62.70
13151	Repair of wound or lesion	3	$91.86	$91.86	Y	$18.37
13152	Repair of wound or lesion	3	$313.49	$313.49	Y	$62.70
13160	Late closure of wound	2	$1,308.85	$446.00		$89.20
14000	Skin tissue rearrangement	2	$821.29	$446.00		$89.20
14001	Skin tissue rearrangement	3	$1,308.85	$510.00		$102.00
14020	Skin tissue rearrangement	3	$821.29	$510.00		$102.00
14021	Skin tissue rearrangement	3	$821.29	$510.00		$102.00
14040	Skin tissue rearrangement	2	$821.29	$446.00		$89.20
14041	Skin tissue rearrangement	3	$821.29	$510.00		$102.00
14060	Skin tissue rearrangement	3	$821.29	$510.00		$102.00
14061	Skin tissue rearrangement	3	$821.29	$510.00		$102.00
14300	Skin tissue rearrangement	4	$1,308.85	$630.00		$126.00
14350	Skin tissue rearrangement	3	$1,308.85	$510.00		$102.00
15000	Wound prep, 1st 100 sq cm	2	$313.49	$313.49	Y	$62.70
15001	Wound prep, addl 100 sq cm	1	$313.49	$313.49	Y	$62.70
15040	Harvest cultured skin graft	2	$91.86	$91.86	Y	$18.37
15050	Skin pinch graft	2	$313.49	$313.49	Y	$62.70
15100	Skin splt grft, trnk/arm/leg	2	$1,308.85	$446.00		$89.20
15101	Skin splt grft t/a/l, add-on	3	$1,308.85	$510.00		$102.00
15110	Epidrm autogrft trnk/arm/leg	2	$1,308.85	$446.00		$89.20
15111	Epidrm autogrft t/a/l add-on	1	$1,308.85	$333.00		$66.60
15115	Epidrm a-grft face/nck/hf/g	2	$1,308.85	$446.00		$89.20
15116	Epidrm a-grft f/n/hf/g addl	1	$1,308.85	$333.00		$66.60
15120	Skn splt a-grft fac/nck/hf/g	2	$1,308.85	$446.00		$89.20
15121	Skn splt a-grft f/n/hf/g add	3	$1,308.85	$510.00		$102.00
15130	Derm autograft, trnk/arm/leg	2	$1,308.85	$446.00		$89.20
15131	Derm autograft t/a/l add-on	1	$1,308.85	$333.00		$66.60
15135	Derm autograft face/nck/hf/g	2	$1,308.85	$446.00		$89.20
15136	Derm autograft, f/n/hf/g add	1	$1,308.85	$333.00		$66.60
15150	Cult epiderm grft t/arm/leg	2	$1,308.85	$446.00		$89.20
15151	Cult epiderm grft t/a/l addl	1	$1,308.85	$333.00		$66.60
15152	Cult epiderm graft t/a/l +%	1	$1,308.85	$333.00		$66.60
15155	Cult epiderm graft, f/n/hf/g	2	$1,308.85	$446.00		$89.20
15156	Cult epidrm grft f/n/hfg add	1	$1,308.85	$333.00		$66.60
15157	Cult epiderm grft f/n/hfg +%	1	$1,308.85	$333.00		$66.60
15200	Skin full graft, trunk	3	$821.29	$510.00		$102.00
15201	Skin full graft trunk add-on	2	$313.49	$313.49	Y	$62.70
15220	Skin full graft sclp/arm/leg	2	$821.29	$446.00		$89.20
15221	Skin full graft add-on	2	$313.49	$313.49	Y	$62.70
15240	Skin full grft face/genit/hf	3	$821.29	$510.00		$102.00
15241	Skin full graft add-on	3	$313.49	$313.49	Y	$62.70
15260	Skin full graft een & lips	2	$821.29	$446.00		$89.20
15261	Skin full graft add-on	2	$313.49	$313.49	Y	$62.70
15300	Apply skinallogrft, t/arm/lg	2	$313.49	$313.49	Y	$62.70
15301	Apply sknallogrft t/a/l addl	1	$313.49	$313.49	Y	$62.70
15320	Apply skin allogrft f/n/hf/g	2	$313.49	$313.49	Y	$62.70
15321	Aply sknallogrft f/n/hfg add	1	$313.49	$313.49	Y	$62.70

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
15330	Aply acell alogrft t/arm/leg	2	$313.49	$313.49	Y	$62.70
15331	Aply acell grft t/a/l add-on	1	$313.49	$313.49	Y	$62.70
15335	Apply acell graft, f/n/hf/g	2	$313.49	$313.49	Y	$62.70
15336	Aply acell grft f/n/hf/g add	1	$313.49	$313.49	Y	$62.70
15400	Apply skin xenograft, t/a/l	2	$313.49	$313.49	Y	$62.70
15401	Apply skn xenogrft t/a/l add	2	$313.49	$313.49	Y	$62.70
15420	Apply skin xgraft, f/n/hf/g	2	$313.49	$313.49	Y	$62.70
15421	Apply skn xgrft f/n/hf/g add	1	$313.49	$313.49	Y	$62.70
15430	Apply acellular xenograft	2	$313.49	$313.49	Y	$62.70
15431	Apply acellular xgraft add	1	$313.49	$313.49	Y	$62.70
15570	Form skin pedicle flap	3	$1,308.85	$510.00		$102.00
15572	Form skin pedicle flap	3	$1,308.85	$510.00		$102.00
15574	Form skin pedicle flap	3	$1,308.85	$510.00		$102.00
15576	Form skin pedicle flap	3	$821.29	$510.00		$102.00
15600	Skin graft	3	$1,308.85	$510.00		$102.00
15610	Skin graft	3	$1,308.85	$510.00		$102.00
15620	Skin graft	4	$1,308.85	$630.00		$126.00
15630	Skin graft	3	$1,308.85	$510.00		$102.00
15650	Transfer skin pedicle flap	5	$1,308.85	$717.00		$143.40
15732	Muscle-skin graft, head/neck	3	$1,308.85	$510.00		$102.00
15734	Muscle-skin graft, trunk	3	$1,308.85	$510.00		$102.00
15736	Muscle-skin graft, arm	3	$1,308.85	$510.00		$102.00
15738	Muscle-skin graft, leg	3	$1,308.85	$510.00		$102.00
15740	Island pedicle flap graft	2	$821.29	$446.00		$89.20
15750	Neurovascular pedicle graft	2	$1,308.85	$446.00		$89.20
15760	Composite skin graft	2	$1,308.85	$446.00		$89.20
15770	Derma-fat-fascia graft	3	$1,308.85	$510.00		$102.00
15775	Hair transplant punch grafts	3	$313.49	$313.49	Y	$62.70
15776	Hair transplant punch grafts	3	$313.49	$313.49	Y	$62.70
15820	Revision of lower eyelid	3	$1,308.85	$510.00		$102.00
15821	Revision of lower eyelid	3	$1,308.85	$510.00		$102.00
15822	Revision of upper eyelid	3	$1,308.85	$510.00		$102.00
15823	Revision of upper eyelid	5	$821.29	$717.00		$143.40
15824	Removal of forehead wrinkles	3	$1,308.85	$510.00		$102.00
15825	Removal of neck wrinkles	3	$1,308.85	$510.00		$102.00
15826	Removal of brow wrinkles	3	$1,308.85	$510.00		$102.00
15828	Removal of face wrinkles	3	$1,308.85	$510.00		$102.00
15829	Removal of skin wrinkles	5	$1,308.85	$717.00		$143.40
15831	Excise excessive skin tissue	3	$1,229.54	$510.00		$102.00
15832	Excise excessive skin tissue	3	$1,229.54	$510.00		$102.00
15833	Excise excessive skin tissue	3	$1,229.54	$510.00		$102.00
15834	Excise excessive skin tissue	3	$1,229.54	$510.00		$102.00
15835	Excise excessive skin tissue	3	$313.49	$313.49	Y	$62.70
15836	Excise excessive skin tissue	3	$920.58	$510.00		$102.00
15839	Excise excessive skin tissue	3	$920.58	$510.00		$102.00
15840	Graft for face nerve palsy	4	$1,308.85	$630.00		$126.00
15841	Graft for face nerve palsy	4	$1,308.85	$630.00		$126.00
15845	Skin and muscle repair, face	4	$1,308.85	$630.00		$126.00
15876	Suction assisted lipectomy	3	$1,308.85	$510.00		$102.00
15877	Suction assisted lipectomy	3	$1,308.85	$510.00		$102.00
15878	Suction assisted lipectomy	3	$821.29	$510.00		$102.00
15879	Suction assisted lipectomy	3	$1,308.85	$510.00		$102.00
15920	Removal of tail bone ulcer	3	$246.96	$246.96	Y	$49.39
15922	Removal of tail bone ulcer	4	$1,308.85	$630.00		$126.00
15931	Remove sacrum pressure sore	3	$1,229.54	$510.00		$102.00
15933	Remove sacrum pressure sore	3	$1,229.54	$510.00		$102.00
15934	Remove sacrum pressure sore	3	$1,308.85	$510.00		$102.00
15935	Remove sacrum pressure sore	4	$1,308.85	$630.00		$126.00
15936	Remove sacrum pressure sore	4	$1,308.85	$630.00		$126.00
15937	Remove sacrum pressure sore	4	$1,308.85	$630.00		$126.00
15940	Remove hip pressure sore	3	$1,229.54	$510.00		$102.00
15941	Remove hip pressure sore	3	$1,229.54	$510.00		$102.00
15944	Remove hip pressure sore	3	$1,308.85	$510.00		$102.00
15945	Remove hip pressure sore	4	$1,308.85	$630.00		$126.00
15946	Remove hip pressure sore	4	$1,308.85	$630.00		$126.00
15950	Remove thigh pressure sore	3	$1,229.54	$510.00		$102.00
15951	Remove thigh pressure sore	4	$1,229.54	$630.00		$126.00
15952	Remove thigh pressure sore	3	$1,308.85	$510.00		$102.00
15953	Remove thigh pressure sore	4	$1,308.85	$630.00		$126.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
15956	Remove thigh pressure sore	3	$1,308.85	$510.00		$102.00
15958	Remove thigh pressure sore	4	$1,308.85	$630.00		$126.00
16025	Dress/debrid p-thick burn, m	2	$66.94	$66.94	Y	$13.39
16030	Dress/debrid p-thick burn, l	2	$98.86	$98.86	Y	$19.77
19020	Incision of breast lesion	2	$1,075.21	$446.00		$89.20
19100	Bx breast percut w/o image	1	$234.21	$234.21	Y	$46.84
19101	Biopsy of breast, open	2	$1,183.32	$446.00		$89.20
19102	Bx breast percut w/image	2	$234.21	$234.21	Y	$46.84
19103	Bx breast percut w/device	2	$396.89	$396.89	Y	$79.38
19110	Nipple exploration	2	$1,183.32	$446.00		$89.20
19112	Excise breast duct fistula	3	$1,183.32	$510.00		$102.00
19120	Removal of breast lesion	3	$1,183.32	$510.00		$102.00
19125	Excision, breast lesion	3	$1,183.32	$510.00		$102.00
19126	Excision, addl breast lesion	3	$1,183.32	$510.00		$102.00
19140	Removal of breast tissue	4	$1,183.32	$630.00		$126.00
19160	Partial mastectomy	3	$1,183.32	$510.00		$102.00
19162	P-mastectomy w/ln removal	7	$2,307.20	$995.00		$199.00
19180	Removal of breast	4	$1,732.69	$630.00		$126.00
19182	Removal of breast	4	$1,732.69	$630.00		$126.00
19296	Place po breast cath for rad	9	$2,508.17	$1,339.00		$267.80
19297	Place breast cath for rad	9	$1,732.69	$1,339.00		$267.80
19298	Place breast rad tube/caths	9	$3,250.00	$1,339.00		$267.80
19316	Suspension of breast	4	$1,732.69	$630.00		$126.00
19318	Reduction of large breast	4	$2,307.20	$630.00		$126.00
19324	Enlarge breast	4	$2,307.20	$630.00		$126.00
19325	Enlarge breast with implant	9	$3,002.43	$1,339.00		$267.80
19328	Removal of breast implant	1	$1,732.69	$333.00		$66.60
19330	Removal of implant material	1	$1,732.69	$333.00		$66.60
19340	Immediate breast prosthesis	2	$2,508.17	$446.00		$89.20
19342	Delayed breast prosthesis	3	$3,002.43	$510.00		$102.00
19350	Breast reconstruction	4	$1,183.32	$630.00		$126.00
19355	Correct inverted nipple(s)	4	$1,732.69	$630.00		$126.00
19357	Breast reconstruction	5	$3,002.43	$717.00		$143.40
19366	Breast reconstruction	5	$1,732.69	$717.00		$143.40
19370	Surgery of breast capsule	4	$1,732.69	$630.00		$126.00
19371	Removal of breast capsule	4	$1,732.69	$630.00		$126.00
19380	Revise breast reconstruction	5	$2,508.17	$717.00		$143.40
20005	Incision of deep abscess	2	$1,281.58	$446.00		$89.20
20200	Muscle biopsy	2	$920.58	$446.00		$89.20
20205	Deep muscle biopsy	3	$920.58	$510.00		$102.00
20206	Needle biopsy, muscle	1	$234.21	$234.21	Y	$46.84
20220	Bone biopsy, trocar/needle	1	$246.96	$246.96	Y	$49.39
20225	Bone biopsy, trocar/needle	2	$400.87	$400.87	Y	$80.17
20240	Bone biopsy, excisional	2	$1,229.54	$446.00		$89.20
20245	Bone biopsy, excisional	3	$1,229.54	$510.00		$102.00
20250	Open bone biopsy	3	$1,281.58	$510.00		$102.00
20251	Open bone biopsy	3	$1,281.58	$510.00		$102.00
20525	Removal of foreign body	3	$1,229.54	$510.00		$102.00
20650	Insert and remove bone pin	3	$1,281.58	$510.00		$102.00
20670	Removal of support implant	1	$920.58	$333.00		$66.60
20680	Removal of support implant	3	$1,229.54	$510.00		$102.00
20690	Apply bone fixation device	2	$1,542.47	$446.00		$89.20
20692	Apply bone fixation device	3	$1,542.47	$510.00		$102.00
20693	Adjust bone fixation device	3	$1,281.58	$510.00		$102.00
20694	Remove bone fixation device	1	$1,281.58	$333.00		$66.60
20900	Removal of bone for graft	3	$1,542.47	$510.00		$102.00
20902	Removal of bone for graft	4	$1,542.47	$630.00		$126.00
20910	Remove cartilage for graft	3	$1,308.85	$510.00		$102.00
20912	Remove cartilage for graft	3	$1,308.85	$510.00		$102.00
20920	Removal of fascia for graft	4	$821.29	$630.00		$126.00
20922	Removal of fascia for graft	3	$1,308.85	$510.00		$102.00
20924	Removal of tendon for graft	4	$1,542.47	$630.00		$126.00
20926	Removal of tissue for graft	4	$821.29	$630.00		$126.00
20975	Electrical bone stimulation	2	$38.23	$38.23	Y	$7.65
21010	Incision of jaw joint	2	$1,425.30	$446.00		$89.20
21015	Resection of facial tumor	3	$1,012.48	$510.00		$102.00
21025	Excision of bone, lower jaw	2	$2,324.90	$446.00		$89.20
21026	Excision of facial bone(s)	2	$2,324.90	$446.00		$89.20
21029	Contour of face bone lesion	2	$2,324.90	$446.00		$89.20

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
21034	Excise max/zygoma mlg tumor	3	$2,324.90	$510.00		$102.00
21040	Excise mandible lesion	2	$1,425.30	$446.00		$89.20
21044	Removal of jaw bone lesion	2	$2,324.90	$446.00		$89.20
21046	Remove mandible cyst complex	2	$2,324.90	$446.00		$89.20
21047	Excise lwr jaw cyst w/repair	2	$2,324.90	$446.00		$89.20
21050	Removal of jaw joint	3	$2,324.90	$510.00		$102.00
21060	Remove jaw joint cartilage	2	$2,324.90	$446.00		$89.20
21070	Remove coronoid process	3	$2,324.90	$510.00		$102.00
21100	Maxillofacial fixation	2	$2,324.90	$446.00		$89.20
21120	Reconstruction of chin	7	$1,425.30	$995.00		$199.00
21121	Reconstruction of chin	7	$1,425.30	$995.00		$199.00
21122	Reconstruction of chin	7	$1,425.30	$995.00		$199.00
21123	Reconstruction of chin	7	$1,425.30	$995.00		$199.00
21125	Augmentation, lower jaw bone	7	$1,425.30	$995.00		$199.00
21127	Augmentation, lower jaw bone	9	$2,324.90	$1,339.00		$267.80
21181	Contour cranial bone lesion	7	$1,425.30	$995.00		$199.00
21206	Reconstruct upper jaw bone	5	$2,324.90	$717.00		$143.40
21208	Augmentation of facial bones	7	$2,324.90	$995.00		$199.00
21209	Reduction of facial bones	5	$2,324.90	$717.00		$143.40
21210	Face bone graft	7	$2,324.90	$995.00		$199.00
21215	Lower jaw bone graft	7	$2,324.90	$995.00		$199.00
21230	Rib cartilage graft	7	$2,324.90	$995.00		$199.00
21235	Ear cartilage graft	7	$1,425.30	$995.00		$199.00
21240	Reconstruction of jaw joint	4	$2,324.90	$630.00		$126.00
21242	Reconstruction of jaw joint	5	$2,324.90	$717.00		$143.40
21243	Reconstruction of jaw joint	5	$2,324.90	$717.00		$143.40
21244	Reconstruction of lower jaw	7	$2,324.90	$995.00		$199.00
21245	Reconstruction of jaw	7	$2,324.90	$995.00		$199.00
21246	Reconstruction of jaw	7	$2,324.90	$995.00		$199.00
21248	Reconstruction of jaw	7	$2,324.90	$995.00		$199.00
21249	Reconstruction of jaw	7	$2,324.90	$995.00		$199.00
21267	Revise eye sockets	7	$2,324.90	$995.00		$199.00
21270	Augmentation, cheek bone	5	$2,324.90	$717.00		$143.40
21275	Revision, orbitofacial bones	7	$2,324.90	$995.00		$199.00
21280	Revision of eyelid	5	$2,324.90	$717.00		$143.40
21282	Revision of eyelid	5	$1,012.48	$717.00		$143.40
21295	Revision of jaw muscle/bone	1	$475.55	$333.00		$66.60
21296	Revision of jaw muscle/bone	1	$1,425.30	$333.00		$66.60
21300	Treatment of skull fracture	2	$1,012.48	$446.00		$89.20
21310	Treatment of nose fracture	2	$146.29	$146.29	Y	$29.26
21315	Treatment of nose fracture	2	$146.29	$146.29	Y	$29.26
21320	Treatment of nose fracture	2	$475.55	$446.00		$89.20
21325	Treatment of nose fracture	4	$1,425.30	$630.00		$126.00
21330	Treatment of nose fracture	5	$1,425.30	$717.00		$143.40
21335	Treatment of nose fracture	7	$1,425.30	$995.00		$199.00
21336	Treat nasal septal fracture	4	$2,312.35	$630.00		$126.00
21337	Treat nasal septal fracture	2	$1,012.48	$446.00		$89.20
21338	Treat nasoethmoid fracture	4	$1,425.30	$630.00		$126.00
21339	Treat nasoethmoid fracture	5	$1,425.30	$717.00		$143.40
21340	Treatment of nose fracture	4	$2,324.90	$630.00		$126.00
21345	Treat nose/jaw fracture	7	$1,425.30	$995.00		$199.00
21355	Treat cheek bone fracture	3	$2,324.90	$510.00		$102.00
21356	Treat cheek bone fracture	3	$1,425.30	$510.00		$102.00
21400	Treat eye socket fracture	2	$475.55	$446.00		$89.20
21401	Treat eye socket fracture	3	$1,012.48	$510.00		$102.00
21421	Treat mouth roof fracture	4	$1,425.30	$630.00		$126.00
21445	Treat dental ridge fracture	4	$1,425.30	$630.00		$126.00
21450	Treat lower jaw fracture	3	$146.29	$146.29	Y	$29.26
21451	Treat lower jaw fracture	4	$475.55	$475.55	Y	$95.11
21452	Treat lower jaw fracture	2	$1,012.48	$446.00		$89.20
21453	Treat lower jaw fracture	3	$2,324.90	$510.00		$102.00
21454	Treat lower jaw fracture	5	$1,425.30	$717.00		$143.40
21461	Treat lower jaw fracture	4	$2,324.90	$630.00		$126.00
21462	Treat lower jaw fracture	5	$2,324.90	$717.00		$143.40
21465	Treat lower jaw fracture	4	$2,324.90	$630.00		$126.00
21480	Reset dislocated jaw	1	$146.29	$146.29	Y	$29.26
21485	Reset dislocated jaw	2	$1,012.48	$446.00		$89.20
21490	Repair dislocated jaw	3	$2,324.90	$510.00		$102.00
21497	Interdental wiring	2	$1,012.48	$446.00		$89.20

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
21501	Drain neck/chest lesion	2	$1,075.21	$446.00		$89.20
21502	Drain chest lesion	2	$1,281.58	$446.00		$89.20
21555	Remove lesion, neck/chest	2	$1,229.54	$446.00		$89.20
21556	Remove lesion, neck/chest	2	$1,229.54	$446.00		$89.20
21600	Partial removal of rib	2	$1,542.47	$446.00		$89.20
21610	Partial removal of rib	2	$1,542.47	$446.00		$89.20
21700	Revision of neck muscle	2	$1,281.58	$446.00		$89.20
21720	Revision of neck muscle	3	$1,281.58	$510.00		$102.00
21725	Revision of neck muscle	3	$91.22	$91.22	Y	$18.24
21800	Treatment of rib fracture	1	$104.11	$104.11	Y	$20.82
21805	Treatment of rib fracture	2	$1,580.03	$446.00		$89.20
21820	Treat sternum fracture	1	$104.11	$104.11	Y	$20.82
21925	Biopsy soft tissue of back	2	$1,229.54	$446.00		$89.20
21930	Remove lesion, back or flank	2	$1,229.54	$446.00		$89.20
21935	Remove tumor, back	3	$1,229.54	$510.00		$102.00
22305	Treat spine process fracture	1	$104.11	$104.11	Y	$20.82
22310	Treat spine fracture	1	$104.11	$104.11	Y	$20.82
22315	Treat spine fracture	2	$104.11	$104.11	Y	$20.82
22505	Manipulation of spine	2	$895.58	$446.00		$89.20
22520	Percutaneous vertebroplasty,	9	$1,542.47	$1339.00		$267.80
22521	Percutaneous vertebroplasty,	9	$1,542.47	$1339.00		$267.80
22522	Percutaneous vertebroplasty,	1	$1,542.47	$373.00		$66.00
22900	Remove abdominal wall lesion	4	$1,229.54	$630.00		$126.00
23000	Removal of calcium deposits	2	$920.58	$446.00		$89.20
23020	Release shoulder joint	2	$2,539.24	$446.00		$89.20
23030	Drain shoulder lesion	1	$1,075.21	$333.00		$66.60
23031	Drain shoulder bursa	3	$1,075.21	$510.00		$102.00
23035	Drain shoulder bone lesion	3	$1,281.58	$510.00		$102.00
23040	Exploratory shoulder surgery	3	$1,542.47	$510.00		$102.00
23044	Exploratory shoulder surgery	4	$1,542.47	$630.00		$126.00
23066	Biopsy shoulder tissues	2	$1,229.54	$446.00		$89.20
23075	Removal of shoulder lesion	2	$920.58	$446.00		$89.20
23076	Removal of shoulder lesion	2	$1,229.54	$446.00		$89.20
23077	Remove tumor of shoulder	3	$1,229.54	$510.00		$102.00
23100	Biopsy of shoulder joint	2	$1,281.58	$446.00		$89.20
23101	Shoulder joint surgery	7	$1,542.47	$995.00		$199.00
23105	Remove shoulder joint lining	4	$1,542.47	$630.00		$126.00
23106	Incision of collarbone joint	4	$1,542.47	$630.00		$126.00
23107	Explore treat shoulder joint	4	$1,542.47	$630.00		$126.00
23120	Partial removal, collar bone	5	$2,539.24	$717.00		$143.40
23125	Removal of collar bone	5	$2,539.24	$717.00		$143.40
23130	Remove shoulder bone, part	5	$2,539.24	$717.00		$143.40
23140	Removal of bone lesion	4	$1,281.58	$630.00		$126.00
23145	Removal of bone lesion	5	$1,542.47	$717.00		$143.40
23146	Removal of bone lesion	5	$1,542.47	$717.00		$143.40
23150	Removal of humerus lesion	4	$1,542.47	$630.00		$126.00
23155	Removal of humerus lesion	5	$1,542.47	$717.00		$143.40
23156	Removal of humerus lesion	5	$1,542.47	$717.00		$143.40
23170	Remove collar bone lesion	2	$1,542.47	$446.00		$89.20
23172	Remove shoulder blade lesion	2	$1,542.47	$446.00		$89.20
23174	Remove humerus lesion	2	$1,542.47	$446.00		$89.20
23180	Remove collar bone lesion	4	$1,542.47	$630.00		$126.00
23182	Remove shoulder blade lesion	4	$1,542.47	$630.00		$126.00
23184	Remove humerus lesion	4	$1,542.47	$630.00		$126.00
23190	Partial removal of scapula	4	$1,542.47	$630.00		$126.00
23195	Removal of head of humerus	5	$1,542.47	$717.00		$143.40
23330	Remove shoulder foreign body	1	$400.87	$333.00		$66.60
23331	Remove shoulder foreign body	1	$1,229.54	$333.00		$66.60
23395	Muscle transfer,shoulder/arm	5	$2,539.24	$717.00		$143.40
23397	Muscle transfers	7	$4,055.26	$995.00		$199.00
23400	Fixation of shoulder blade	7	$1,542.47	$995.00		$199.00
23405	Incision of tendon & muscle	2	$1,542.47	$446.00		$89.20
23406	Incise tendon(s) & muscle(s)	2	$1,542.47	$446.00		$89.20
23410	Repair rotator cuff, acute	5	$2,539.24	$717.00		$143.40
23412	Repair rotator cuff, chronic	7	$2,539.24	$995.00		$199.00
23415	Release of shoulder ligament	5	$2,539.24	$717.00		$143.40
23420	Repair of shoulder	7	$2,539.24	$995.00		$199.00
23430	Repair biceps tendon	4	$2,539.24	$630.00		$126.00
23440	Remove/transplant tendon	4	$2,539.24	$630.00		$126.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
23450	Repair shoulder capsule	5	$4,055.26	$717.00		$143.40
23455	Repair shoulder capsule	7	$4,055.26	$995.00		$199.00
23460	Repair shoulder capsule	5	$4,055.26	$717.00		$143.40
23462	Repair shoulder capsule	7	$2,539.24	$995.00		$199.00
23465	Repair shoulder capsule	5	$4,055.26	$717.00		$143.40
23466	Repair shoulder capsule	7	$2,539.24	$995.00		$199.00
23480	Revision of collar bone	4	$2,539.24	$630.00		$126.00
23485	Revision of collar bone	7	$4,055.26	$995.00		$199.00
23490	Reinforce clavicle	3	$2,539.24	$510.00		$102.00
23491	Reinforce shoulder bones	3	$4,055.26	$510.00		$102.00
23500	Treat clavicle fracture	1	$104.11	$104.11	Y	$20.82
23505	Treat clavicle fracture	1	$104.11	$104.11	Y	$20.82
23515	Treat clavicle fracture	3	$3,472.68	$510.00		$102.00
23520	Treat clavicle dislocation	1	$104.11	$104.11	Y	$20.82
23525	Treat clavicle dislocation	1	$104.11	$104.11	Y	$20.82
23530	Treat clavicle dislocation	3	$2,312.35	$510.00		$102.00
23532	Treat clavicle dislocation	4	$1,580.03	$630.00		$126.00
23540	Treat clavicle dislocation	1	$104.11	$104.11	Y	$20.82
23545	Treat clavicle dislocation	1	$104.11	$104.11	Y	$20.82
23550	Treat clavicle dislocation	3	$2,312.35	$510.00		$102.00
23552	Treat clavicle dislocation	4	$2,312.35	$630.00		$126.00
23570	Treat shoulder blade fx	1	$104.11	$104.11	Y	$20.82
23575	Treat shoulder blade fx	1	$104.11	$104.11	Y	$20.82
23585	Treat scapula fracture	3	$3,472.68	$510.00		$102.00
23605	Treat humerus fracture	2	$104.11	$104.11	Y	$20.82
23615	Treat humerus fracture	4	$3,472.68	$630.00		$126.00
23616	Treat humerus fracture	4	$3,472.68	$630.00		$126.00
23625	Treat humerus fracture	2	$104.11	$104.11	Y	$20.82
23630	Treat humerus fracture	5	$3,472.68	$717.00		$143.40
23650	Treat shoulder dislocation	1	$104.11	$104.11	Y	$20.82
23655	Treat shoulder dislocation	1	$895.58	$333.00		$66.60
23660	Treat shoulder dislocation	3	$2,312.35	$510.00		$102.00
23665	Treat dislocation/fracture	2	$104.11	$104.11	Y	$20.82
23670	Treat dislocation/fracture	3	$3,472.68	$510.00		$102.00
23675	Treat dislocation/fracture	2	$104.11	$104.11	Y	$20.82
23680	Treat dislocation/fracture	3	$2,312.35	$510.00		$102.00
23700	Fixation of shoulder	1	$895.58	$333.00		$66.60
23800	Fusion of shoulder joint	4	$4,055.26	$630.00		$126.00
23802	Fusion of shoulder joint	7	$2,539.24	$995.00		$199.00
23921	Amputation follow-up surgery	3	$313.49	$313.49	Y	$62.70
23930	Drainage of arm lesion	1	$1,075.21	$333.00		$66.60
23931	Drainage of arm bursa	2	$1,075.21	$446.00		$89.20
23935	Drain arm/elbow bone lesion	2	$1,281.58	$446.00		$89.20
24000	Exploratory elbow surgery	4	$1,542.47	$630.00		$126.00
24006	Release elbow joint	4	$1,542.47	$630.00		$126.00
24066	Biopsy arm/elbow soft tissue	2	$920.58	$446.00		$89.20
24075	Remove arm/elbow lesion	2	$920.58	$446.00		$89.20
24076	Remove arm/elbow lesion	2	$1,229.54	$446.00		$89.20
24077	Remove tumor of arm/elbow	3	$1,229.54	$510.00		$102.00
24100	Biopsy elbow joint lining	1	$1,281.58	$333.00		$66.60
24101	Explore/treat elbow joint	4	$1,542.47	$630.00		$126.00
24102	Remove elbow joint lining	4	$1,542.47	$630.00		$126.00
24105	Removal of elbow bursa	3	$1,281.58	$510.00		$102.00
24110	Remove humerus lesion	2	$1,281.58	$446.00		$89.20
24115	Remove/graft bone lesion	3	$1,542.47	$510.00		$102.00
24116	Remove/graft bone lesion	3	$1,542.47	$510.00		$102.00
24120	Remove elbow lesion	3	$1,281.58	$510.00		$102.00
24125	Remove/graft bone lesion	3	$1,542.47	$510.00		$102.00
24126	Remove/graft bone lesion	3	$1,542.47	$510.00		$102.00
24130	Removal of head of radius	3	$1,542.47	$510.00		$102.00
24134	Removal of arm bone lesion	2	$1,542.47	$446.00		$89.20
24136	Remove radius bone lesion	2	$1,542.47	$446.00		$89.20
24138	Remove elbow bone lesion	2	$1,542.47	$446.00		$89.20
24140	Partial removal of arm bone	3	$1,542.47	$510.00		$102.00
24145	Partial removal of radius	3	$1,542.47	$510.00		$102.00
24147	Partial removal of elbow	2	$1,542.47	$446.00		$89.20
24155	Removal of elbow joint	3	$2,539.24	$510.00		$102.00
24160	Remove elbow joint implant	2	$1,542.47	$446.00		$89.20
24164	Remove radius head implant	3	$1,542.47	$510.00		$102.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
24201	Removal of arm foreign body	2	$920.58	$446.00		$89.20
24301	Muscle/tendon transfer	4	$1,542.47	$630.00		$126.00
24305	Arm tendon lengthening	4	$1,542.47	$630.00		$126.00
24310	Revision of arm tendon	3	$1,281.58	$510.00		$102.00
24320	Repair of arm tendon	3	$2,539.24	$510.00		$102.00
24330	Revision of arm muscles	3	$4,055.26	$510.00		$102.00
24331	Revision of arm muscles	3	$2,539.24	$510.00		$102.00
24340	Repair of biceps tendon	3	$2,539.24	$510.00		$102.00
24341	Repair arm tendon/muscle	3	$2,539.24	$510.00		$102.00
24342	Repair of ruptured tendon	3	$2,539.24	$510.00		$102.00
24345	Repr elbw med ligmnt w/tissu	2	$1,542.47	$446.00		$89.20
24350	Repair of tennis elbow	3	$1,542.47	$510.00		$102.00
24351	Repair of tennis elbow	3	$1,542.47	$510.00		$102.00
24352	Repair of tennis elbow	3	$1,542.47	$510.00		$102.00
24354	Repair of tennis elbow	3	$1,542.47	$510.00		$102.00
24356	Revision of tennis elbow	3	$1,542.47	$510.00		$102.00
24360	Reconstruct elbow joint	5	$2,016.06	$717.00		$143.40
24361	Reconstruct elbow joint	5	$6,473.11	$717.00		$143.40
24362	Reconstruct elbow joint	5	$2,903.02	$717.00		$143.40
24363	Replace elbow joint	7	$6,473.11	$995.00		$199.00
24365	Reconstruct head of radius	5	$2,016.06	$717.00		$143.40
24366	Reconstruct head of radius	5	$6,473.11	$717.00		$143.40
24400	Revision of humerus	4	$1,542.47	$630.00		$126.00
24410	Revision of humerus	4	$1,542.47	$630.00		$126.00
24420	Revision of humerus	3	$2,539.24	$510.00		$102.00
24430	Repair of humerus	3	$4,055.26	$510.00		$102.00
24435	Repair humerus with graft	4	$4,055.26	$630.00		$126.00
24470	Revision of elbow joint	3	$2,539.24	$510.00		$102.00
24495	Decompression of forearm	2	$1,542.47	$446.00		$89.20
24498	Reinforce humerus	3	$4,055.26	$510.00		$102.00
24500	Treat humerus fracture	1	$104.11	$104.11	Y	$20.82
24505	Treat humerus fracture	1	$104.11	$104.11	Y	$20.82
24515	Treat humerus fracture	4	$3,472.68	$630.00		$126.00
24516	Treat humerus fracture	4	$3,472.68	$630.00		$126.00
24530	Treat humerus fracture	1	$104.11	$104.11	Y	$20.82
24535	Treat humerus fracture	1	$104.11	$104.11	Y	$20.82
24538	Treat humerus fracture	2	$1,580.03	$446.00		$89.20
24545	Treat humerus fracture	4	$3,472.68	$630.00		$126.00
24546	Treat humerus fracture	5	$3,472.68	$717.00		$143.40
24560	Treat humerus fracture	1	$104.11	$104.11	Y	$20.82
24565	Treat humerus fracture	2	$104.11	$104.11	Y	$20.82
24566	Treat humerus fracture	2	$1,580.03	$446.00		$89.20
24575	Treat humerus fracture	3	$3,472.68	$510.00		$102.00
24576	Treat humerus fracture	1	$104.11	$104.11	Y	$20.82
24577	Treat humerus fracture	1	$104.11	$104.11	Y	$20.82
24579	Treat humerus fracture	3	$3,472.68	$510.00		$102.00
24582	Treat humerus fracture	2	$1,580.03	$446.00		$89.20
24586	Treat elbow fracture	4	$3,472.68	$630.00		$126.00
24587	Treat elbow fracture	5	$3,472.68	$717.00		$143.40
24600	Treat elbow dislocation	1	$104.11	$104.11	Y	$20.82
24605	Treat elbow dislocation	2	$895.58	$446.00		$89.20
24615	Treat elbow dislocation	3	$3,472.68	$510.00		$102.00
24620	Treat elbow fracture	2	$104.11	$104.11	Y	$20.82
24635	Treat elbow fracture	3	$3,472.68	$510.00		$102.00
24655	Treat radius fracture	1	$104.11	$104.11	Y	$20.82
24665	Treat radius fracture	4	$2,312.35	$630.00		$126.00
24666	Treat radius fracture	4	$3,472.68	$630.00		$126.00
24670	Treat ulnar fracture	1	$104.11	$104.11	Y	$20.82
24675	Treat ulnar fracture	1	$104.11	$104.11	Y	$20.82
24685	Treat ulnar fracture	3	$2,312.35	$510.00		$102.00
24800	Fusion of elbow joint	4	$2,539.24	$630.00		$126.00
24802	Fusion/graft of elbow joint	5	$2,539.24	$717.00		$143.40
24925	Amputation follow-up surgery	3	$1,281.58	$510.00		$102.00
25000	Incision of tendon sheath	3	$1,281.58	$510.00		$102.00
25020	Decompress forearm 1 space	3	$1,281.58	$510.00		$102.00
25023	Decompress forearm 1 space	3	$1,542.47	$510.00		$102.00
25024	Decompress forearm 2 spaces	3	$1,542.47	$510.00		$102.00
25025	Decompress forearm 2 spaces	3	$1,542.47	$510.00		$102.00
25028	Drainage of forearm lesion	1	$1,281.58	$333.00		$66.60

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
25031	Drainage of forearm bursa	2	$1,281.58	$446.00		$89.20
25035	Treat forearm bone lesion	2	$1,281.58	$446.00		$89.20
25040	Explore/treat wrist joint	5	$1,542.47	$717.00		$143.40
25066	Biopsy forearm soft tissues	2	$1,229.54	$446.00		$89.20
25075	Removal forearm lesion subcu	2	$920.58	$446.00		$89.20
25076	Removal forearm lesion deep	3	$1,229.54	$510.00		$102.00
25077	Remove tumor, forearm/wrist	3	$1,229.54	$510.00		$102.00
25085	Incision of wrist capsule	3	$1,281.58	$510.00		$102.00
25100	Biopsy of wrist joint	2	$1,281.58	$446.00		$89.20
25101	Explore/treat wrist joint	3	$1,542.47	$510.00		$102.00
25105	Remove wrist joint lining	4	$1,542.47	$630.00		$126.00
25107	Remove wrist joint cartilage	3	$1,542.47	$510.00		$102.00
25110	Remove wrist tendon lesion	3	$1,281.58	$510.00		$102.00
25111	Remove wrist tendon lesion	3	$986.93	$510.00		$102.00
25112	Reremove wrist tendon lesion	4	$986.93	$630.00		$126.00
25115	Remove wrist/forearm lesion	4	$1,281.58	$630.00		$126.00
25116	Remove wrist/forearm lesion	4	$1,281.58	$630.00		$126.00
25118	Excise wrist tendon sheath	2	$1,542.47	$446.00		$89.20
25119	Partial removal of ulna	3	$1,542.47	$510.00		$102.00
25120	Removal of forearm lesion	3	$1,542.47	$510.00		$102.00
25125	Remove/graft forearm lesion	3	$1,542.47	$510.00		$102.00
25126	Remove/graft forearm lesion	3	$1,542.47	$510.00		$102.00
25130	Removal of wrist lesion	3	$1,542.47	$510.00		$102.00
25135	Remove & graft wrist lesion	3	$1,542.47	$510.00		$102.00
25136	Remove & graft wrist lesion	3	$1,542.47	$510.00		$102.00
25145	Remove forearm bone lesion	2	$1,542.47	$446.00		$89.20
25150	Partial removal of ulna	2	$1,542.47	$446.00		$89.20
25151	Partial removal of radius	2	$1,542.47	$446.00		$89.20
25210	Removal of wrist bone	3	$1,590.63	$510.00		$102.00
25215	Removal of wrist bones	4	$1,590.63	$630.00		$126.00
25230	Partial removal of radius	4	$1,542.47	$630.00		$126.00
25240	Partial removal of ulna	4	$1,542.47	$630.00		$126.00
25248	Remove forearm foreign body	2	$1,281.58	$446.00		$89.20
25250	Removal of wrist prosthesis	1	$1,542.47	$333.00		$66.60
25251	Removal of wrist prosthesis	1	$1,542.47	$333.00		$66.60
25260	Repair forearm tendon/muscle	4	$1,542.47	$630.00		$126.00
25263	Repair forearm tendon/muscle	2	$1,542.47	$446.00		$89.20
25265	Repair forearm tendon/muscle	3	$1,542.47	$510.00		$102.00
25270	Repair forearm tendon/muscle	4	$1,542.47	$630.00		$126.00
25272	Repair forearm tendon/muscle	3	$1,542.47	$510.00		$102.00
25274	Repair forearm tendon/muscle	4	$1,542.47	$630.00		$126.00
25275	Repair forearm tendon sheath	4	$1,542.47	$630.00		$126.00
25280	Revise wrist/forearm tendon	4	$1,542.47	$630.00		$126.00
25290	Incise wrist/forearm tendon	3	$1,542.47	$510.00		$102.00
25295	Release wrist/forearm tendon	3	$1,281.58	$510.00		$102.00
25300	Fusion of tendons at wrist	3	$1,542.47	$510.00		$102.00
25301	Fusion of tendons at wrist	3	$1,542.47	$510.00		$102.00
25310	Transplant forearm tendon	3	$2,539.24	$510.00		$102.00
25312	Transplant forearm tendon	4	$2,539.24	$630.00		$126.00
25315	Revise palsy hand tendon(s)	3	$2,539.24	$510.00		$102.00
25316	Revise palsy hand tendon(s)	3	$4,055.26	$510.00		$102.00
25320	Repair/revise wrist joint	3	$2,539.24	$510.00		$102.00
25332	Revise wrist joint	5	$2,016.06	$717.00		$143.40
25335	Realignment of hand	3	$2,539.24	$510.00		$102.00
25337	Reconstruct ulna/radioulnar	5	$2,539.24	$717.00		$143.40
25350	Revision of radius	3	$4,055.26	$510.00		$102.00
25355	Revision of radius	3	$2,539.24	$510.00		$102.00
25360	Revision of ulna	3	$1,542.47	$510.00		$102.00
25365	Revise radius & ulna	3	$1,542.47	$510.00		$102.00
25370	Revise radius or ulna	3	$2,539.24	$510.00		$102.00
25375	Revise radius & ulna	4	$2,539.24	$630.00		$126.00
25390	Shorten radius or ulna	3	$1,542.47	$510.00		$102.00
25391	Lengthen radius or ulna	4	$2,539.24	$630.00		$126.00
25392	Shorten radius & ulna	3	$1,542.47	$510.00		$102.00
25393	Lengthen radius & ulna	4	$2,539.24	$630.00		$126.00
25400	Repair radius or ulna	3	$1,542.47	$510.00		$102.00
25405	Repair/graft radius or ulna	4	$1,542.47	$630.00		$126.00
25415	Repair radius & ulna	3	$1,542.47	$510.00		$102.00
25420	Repair/graft radius & ulna	4	$4,055.26	$630.00		$126.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
25425	Repair/graft radius or ulna	3	$2,539.24	$510.00		$102.00
25426	Repair/graft radius & ulna	4	$2,539.24	$630.00		$126.00
25440	Repair/graft wrist bone	4	$4,055.26	$630.00		$126.00
25441	Reconstruct wrist joint	5	$6,473.11	$717.00		$143.40
25442	Reconstruct wrist joint	5	$6,473.11	$717.00		$143.40
25443	Reconstruct wrist joint	5	$2,903.02	$717.00		$143.40
25444	Reconstruct wrist joint	5	$2,903.02	$717.00		$143.40
25445	Reconstruct wrist joint	5	$2,903.02	$717.00		$143.40
25446	Wrist replacement	7	$6,473.11	$995.00		$199.00
25447	Repair wrist joint(s)	5	$2,016.06	$717.00		$143.40
25449	Remove wrist joint implant	5	$2,016.06	$717.00		$143.40
25450	Revision of wrist joint	3	$2,539.24	$510.00		$102.00
25455	Revision of wrist joint	3	$2,539.24	$510.00		$102.00
25490	Reinforce radius	3	$2,539.24	$510.00		$102.00
25491	Reinforce ulna	3	$2,539.24	$510.00		$102.00
25492	Reinforce radius and ulna	3	$2,539.24	$510.00		$102.00
25505	Treat fracture of radius	1	$104.11	$104.11	Y	$20.82
25515	Treat fracture of radius	3	$2,312.35	$510.00		$102.00
25520	Treat fracture of radius	1	$104.11	$104.11	Y	$20.82
25525	Treat fracture of radius	4	$2,312.35	$630.00		$126.00
25526	Treat fracture of radius	5	$2,312.35	$717.00		$143.40
25535	Treat fracture of ulna	1	$104.11	$104.11	Y	$20.82
25545	Treat fracture of ulna	3	$2,312.35	$510.00		$102.00
25565	Treat fracture radius & ulna	2	$104.11	$104.11	Y	$20.82
25574	Treat fracture radius & ulna	3	$3,472.68	$510.00		$102.00
25575	Treat fracture radius/ulna	3	$3,472.68	$510.00		$102.00
25605	Treat fracture radius/ulna	3	$104.11	$104.11	Y	$20.82
25611	Treat fracture radius/ulna	3	$1,580.03	$510.00		$102.00
25620	Treat fracture radius/ulna	5	$3,472.68	$717.00		$143.40
25624	Treat wrist bone fracture	2	$104.11	$104.11	Y	$20.82
25628	Treat wrist bone fracture	3	$2,312.35	$510.00		$102.00
25635	Treat wrist bone fracture	1	$104.11	$104.11	Y	$20.82
25645	Treat wrist bone fracture	3	$2,312.35	$510.00		$102.00
25660	Treat wrist dislocation	1	$104.11	$104.11	Y	$20.82
25670	Treat wrist dislocation	3	$1,580.03	$510.00		$102.00
25671	Pin radioulnar dislocation	1	$1,580.03	$333.00		$66.60
25675	Treat wrist dislocation	1	$104.11	$104.11	Y	$20.82
25676	Treat wrist dislocation	2	$1,580.03	$446.00		$89.20
25680	Treat wrist fracture	2	$104.11	$104.11	Y	$20.82
25685	Treat wrist fracture	3	$1,580.03	$510.00		$102.00
25690	Treat wrist dislocation	1	$104.11	$104.11	Y	$20.82
25695	Treat wrist dislocation	2	$1,580.03	$446.00		$89.20
25800	Fusion of wrist joint	4	$4,055.26	$630.00		$126.00
25805	Fusion/graft of wrist joint	5	$2,539.24	$717.00		$143.40
25810	Fusion/graft of wrist joint	5	$4,055.26	$717.00		$143.40
25820	Fusion of hand bones	4	$986.93	$630.00		$126.00
25825	Fuse hand bones with graft	5	$1,590.63	$717.00		$143.40
25830	Fusion, radioulnar jnt/ulna	5	$4,055.26	$717.00		$143.40
25907	Amputation follow-up surgery	3	$1,281.58	$510.00		$102.00
25922	Amputate hand at wrist	3	$1,281.58	$510.00		$102.00
25929	Amputation follow-up surgery	3	$821.29	$510.00		$102.00
26011	Drainage of finger abscess	1	$672.04	$333.00		$66.60
26020	Drain hand tendon sheath	2	$986.93	$446.00		$89.20
26025	Drainage of palm bursa	1	$986.93	$333.00		$66.60
26030	Drainage of palm bursa(s)	2	$986.93	$446.00		$89.20
26034	Treat hand bone lesion	2	$986.93	$446.00		$89.20
26040	Release palm contracture	4	$1,590.63	$630.00		$126.00
26045	Release palm contracture	3	$1,590.63	$510.00		$102.00
26055	Incise finger tendon sheath	2	$986.93	$446.00		$89.20
26060	Incision of finger tendon	2	$986.93	$446.00		$89.20
26070	Explore/treat hand joint	2	$986.93	$446.00		$89.20
26075	Explore/treat finger joint	4	$986.93	$630.00		$126.00
26080	Explore/treat finger joint	4	$986.93	$630.00		$126.00
26100	Biopsy hand joint lining	2	$986.93	$446.00		$89.20
26105	Biopsy finger joint lining	1	$986.93	$333.00		$66.60
26110	Biopsy finger joint lining	1	$986.93	$333.00		$66.60
26115	Removal hand lesion subcut	2	$1,229.54	$446.00		$89.20
26116	Removal hand lesion, deep	2	$1,229.54	$446.00		$89.20
26117	Remove tumor, hand/finger	3	$1,229.54	$510.00		$102.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
26121	Release palm contracture	4	$1,590.63	$630.00		$126.00
26123	Release palm contracture	4	$1,590.63	$630.00		$126.00
26125	Release palm contracture	4	$986.93	$630.00		$126.00
26130	Remove wrist joint lining	3	$986.93	$510.00		$102.00
26135	Revise finger joint, each	4	$1,590.63	$630.00		$126.00
26140	Revise finger joint, each	2	$986.93	$446.00		$89.20
26145	Tendon excision, palm/finger	3	$986.93	$510.00		$102.00
26160	Remove tendon sheath lesion	3	$986.93	$510.00		$102.00
26170	Removal of palm tendon, each	3	$986.93	$510.00		$102.00
26180	Removal of finger tendon	3	$986.93	$510.00		$102.00
26185	Remove finger bone	4	$986.93	$630.00		$126.00
26200	Remove hand bone lesion	2	$986.93	$446.00		$89.20
26205	Remove/graft bone lesion	3	$1,590.63	$510.00		$102.00
26210	Removal of finger lesion	2	$986.93	$446.00		$89.20
26215	Remove/graft finger lesion	3	$986.93	$510.00		$102.00
26230	Partial removal of hand bone	7	$986.93	$986.93	Y	$197.39
26235	Partial removal, finger bone	3	$986.93	$510.00		$102.00
26236	Partial removal, finger bone	3	$986.93	$510.00		$102.00
26250	Extensive hand surgery	3	$986.93	$510.00		$102.00
26255	Extensive hand surgery	3	$1,590.63	$510.00		$102.00
26260	Extensive finger surgery	3	$986.93	$510.00		$102.00
26261	Extensive finger surgery	3	$986.93	$510.00		$102.00
26262	Partial removal of finger	2	$986.93	$446.00		$89.20
26320	Removal of implant from hand	2	$920.58	$446.00		$89.20
26350	Repair finger/hand tendon	1	$1,590.63	$333.00		$66.60
26352	Repair/graft hand tendon	4	$1,590.63	$630.00		$126.00
26356	Repair finger/hand tendon	4	$1,590.63	$630.00		$126.00
26357	Repair finger/hand tendon	4	$1,590.63	$630.00		$126.00
26358	Repair/graft hand tendon	4	$1,590.63	$630.00		$126.00
26370	Repair finger/hand tendon	4	$1,590.63	$630.00		$126.00
26372	Repair/graft hand tendon	4	$1,590.63	$630.00		$126.00
26373	Repair finger/hand tendon	3	$1,590.63	$510.00		$102.00
26390	Revise hand/finger tendon	4	$1,590.63	$630.00		$126.00
26392	Repair/graft hand tendon	3	$1,590.63	$510.00		$102.00
26410	Repair hand tendon	3	$986.93	$510.00		$102.00
26412	Repair/graft hand tendon	3	$1,590.63	$510.00		$102.00
26415	Excision, hand/finger tendon	4	$1,590.63	$630.00		$126.00
26416	Graft hand or finger tendon	3	$1,590.63	$510.00		$102.00
26418	Repair finger tendon	4	$986.93	$630.00		$126.00
26420	Repair/graft finger tendon	4	$1,590.63	$630.00		$126.00
26426	Repair finger/hand tendon	3	$1,590.63	$510.00		$102.00
26428	Repair/graft finger tendon	3	$1,590.63	$510.00		$102.00
26432	Repair finger tendon	3	$986.93	$510.00		$102.00
26433	Repair finger tendon	3	$986.93	$510.00		$102.00
26434	Repair/graft finger tendon	3	$1,590.63	$510.00		$102.00
26437	Realignment of tendons	3	$986.93	$510.00		$102.00
26440	Release palm/finger tendon	3	$986.93	$510.00		$102.00
26442	Release palm & finger tendon	3	$1,590.63	$510.00		$102.00
26445	Release hand/finger tendon	3	$986.93	$510.00		$102.00
26449	Release forearm/hand tendon	3	$1,590.63	$510.00		$102.00
26450	Incision of palm tendon	3	$986.93	$510.00		$102.00
26455	Incision of finger tendon	3	$986.93	$510.00		$102.00
26460	Incise hand/finger tendon	3	$986.93	$510.00		$102.00
26471	Fusion of finger tendons	2	$986.93	$446.00		$89.20
26474	Fusion of finger tendons	2	$986.93	$446.00		$89.20
26476	Tendon lengthening	1	$986.93	$333.00		$66.60
26477	Tendon shortening	1	$986.93	$333.00		$66.60
26478	Lengthening of hand tendon	1	$986.93	$333.00		$66.60
26479	Shortening of hand tendon	1	$986.93	$333.00		$66.60
26480	Transplant hand tendon	3	$1,590.63	$510.00		$102.00
26483	Transplant/graft hand tendon	3	$1,590.63	$510.00		$102.00
26485	Transplant palm tendon	2	$1,590.63	$446.00		$89.20
26489	Transplant/graft palm tendon	3	$1,590.63	$510.00		$102.00
26490	Revise thumb tendon	3	$1,590.63	$510.00		$102.00
26492	Tendon transfer with graft	3	$1,590.63	$510.00		$102.00
26494	Hand tendon/muscle transfer	3	$1,590.63	$510.00		$102.00
26496	Revise thumb tendon	3	$1,590.63	$510.00		$102.00
26497	Finger tendon transfer	3	$1,590.63	$510.00		$102.00
26498	Finger tendon transfer	4	$1,590.63	$630.00		$126.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
26499	Revision of finger	3	$1,590.63	$510.00		$102.00
26500	Hand tendon reconstruction	4	$986.93	$630.00		$126.00
26502	Hand tendon reconstruction	4	$1,590.63	$630.00		$126.00
26504	Hand tendon reconstruction	4	$1,590.63	$630.00		$126.00
26508	Release thumb contracture	3	$986.93	$510.00		$102.00
26510	Thumb tendon transfer	3	$1,590.63	$510.00		$102.00
26516	Fusion of knuckle joint	1	$1,590.63	$333.00		$66.60
26517	Fusion of knuckle joints	3	$1,590.63	$510.00		$102.00
26518	Fusion of knuckle joints	3	$1,590.63	$510.00		$102.00
26520	Release knuckle contracture	3	$986.93	$510.00		$102.00
26525	Release finger contracture	3	$986.93	$510.00		$102.00
26530	Revise knuckle joint	3	$2,016.06	$510.00		$102.00
26531	Revise knuckle with implant	7	$2,903.02	$995.00		$199.00
26535	Revise finger joint	5	$2,016.06	$717.00		$143.40
26536	Revise/implant finger joint	5	$2,903.02	$717.00		$143.40
26540	Repair hand joint	4	$986.93	$630.00		$126.00
26541	Repair hand joint with graft	7	$1,590.63	$995.00		$199.00
26542	Repair hand joint with graft	4	$986.93	$630.00		$126.00
26545	Reconstruct finger joint	4	$1,590.63	$630.00		$126.00
26546	Repair nonunion hand	4	$1,590.63	$630.00		$126.00
26548	Reconstruct finger joint	4	$1,590.63	$630.00		$126.00
26550	Construct thumb replacement	2	$1,590.63	$446.00		$89.20
26555	Positional change of finger	3	$1,590.63	$510.00		$102.00
26560	Repair of web finger	2	$986.93	$446.00		$89.20
26561	Repair of web finger	3	$1,590.63	$510.00		$102.00
26562	Repair of web finger	4	$1,590.63	$630.00		$126.00
26565	Correct metacarpal flaw	5	$1,590.63	$717.00		$143.40
26567	Correct finger deformity	5	$1,590.63	$717.00		$143.40
26568	Lengthen metacarpal/finger	3	$1,590.63	$510.00		$102.00
26580	Repair hand deformity	5	$986.93	$717.00		$143.40
26587	Reconstruct extra finger	5	$986.93	$717.00		$143.40
26590	Repair finger deformity	5	$986.93	$717.00		$143.40
26591	Repair muscles of hand	3	$1,590.63	$510.00		$102.00
26593	Release muscles of hand	3	$986.93	$510.00		$102.00
26596	Excision constricting tissue	2	$986.93	$446.00		$89.20
26605	Treat metacarpal fracture	2	$104.11	$104.11	Y	$20.82
26607	Treat metacarpal fracture	2	$104.11	$104.11	Y	$20.82
26608	Treat metacarpal fracture	4	$1,580.03	$630.00		$126.00
26615	Treat metacarpal fracture	4	$2,312.35	$630.00		$126.00
26645	Treat thumb fracture	1	$104.11	$104.11	Y	$20.82
26650	Treat thumb fracture	2	$1,580.03	$446.00		$89.20
26665	Treat thumb fracture	4	$2,312.35	$630.00		$126.00
26675	Treat hand dislocation	2	$104.11	$104.11	Y	$20.82
26676	Pin hand dislocation	2	$1,580.03	$446.00		$89.20
26685	Treat hand dislocation	3	$2,312.35	$510.00		$102.00
26686	Treat hand dislocation	3	$3,472.68	$510.00		$102.00
26705	Treat knuckle dislocation	2	$104.11	$104.11	Y	$20.82
26706	Pin knuckle dislocation	2	$104.11	$104.11	Y	$20.82
26715	Treat knuckle dislocation	4	$2,312.35	$630.00		$126.00
26727	Treat finger fracture, each	7	$1,580.03	$995.00		$199.00
26735	Treat finger fracture, each	4	$2,312.35	$630.00		$126.00
26742	Treat finger fracture, each	2	$104.11	$104.11	Y	$20.82
26746	Treat finger fracture, each	5	$2,312.35	$717.00		$143.40
26756	Pin finger fracture, each	2	$1,580.03	$446.00		$89.20
26765	Treat finger fracture, each	4	$2,312.35	$630.00		$126.00
26776	Pin finger dislocation	2	$1,580.03	$446.00		$89.20
26785	Treat finger dislocation	2	$1,580.03	$446.00		$89.20
26820	Thumb fusion with graft	5	$1,590.63	$717.00		$143.40
26841	Fusion of thumb	4	$1,590.63	$630.00		$126.00
26842	Thumb fusion with graft	4	$1,590.63	$630.00		$126.00
26843	Fusion of hand joint	3	$1,590.63	$510.00		$102.00
26844	Fusion/graft of hand joint	3	$1,590.63	$510.00		$102.00
26850	Fusion of knuckle	4	$1,590.63	$630.00		$126.00
26852	Fusion of knuckle with graft	4	$1,590.63	$630.00		$126.00
26860	Fusion of finger joint	3	$1,590.63	$510.00		$102.00
26861	Fusion of finger jnt, add-on	2	$1,590.63	$446.00		$89.20
26862	Fusion/graft of finger joint	4	$1,590.63	$630.00		$126.00
26863	Fuse/graft added joint	3	$1,590.63	$510.00		$102.00
26910	Amputate metacarpal bone	3	$1,590.63	$510.00		$102.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
26951	Amputation of finger/thumb	2	$986.93	$446.00		$89.20
26952	Amputation of finger/thumb	4	$986.93	$630.00		$126.00
26990	Drainage of pelvis lesion	1	$1,281.58	$333.00		$66.60
26991	Drainage of pelvis bursa	1	$1,281.58	$333.00		$66.60
27000	Incision of hip tendon	2	$1,281.58	$446.00		$89.20
27001	Incision of hip tendon	3	$1,542.47	$510.00		$102.00
27003	Incision of hip tendon	3	$1,542.47	$510.00		$102.00
27033	Exploration of hip joint	3	$2,539.24	$510.00		$102.00
27035	Denervation of hip joint	4	$2,539.24	$630.00		$126.00
27040	Biopsy of soft tissues	1	$400.87	$333.00		$66.60
27041	Biopsy of soft tissues	2	$400.87	$400.87	Y	$80.17
27047	Remove hip/pelvis lesion	2	$1,229.54	$446.00		$89.20
27048	Remove hip/pelvis lesion	3	$1,229.54	$510.00		$102.00
27049	Remove tumor, hip/pelvis	3	$1,229.54	$510.00		$102.00
27050	Biopsy of sacroiliac joint	3	$1,281.58	$510.00		$102.00
27052	Biopsy of hip joint	3	$1,281.58	$510.00		$102.00
27060	Removal of ischial bursa	5	$1,281.58	$717.00		$143.40
27062	Remove femur lesion/bursa	5	$1,281.58	$717.00		$143.40
27065	Removal of hip bone lesion	5	$1,281.58	$717.00		$143.40
27066	Removal of hip bone lesion	5	$1,542.47	$717.00		$143.40
27067	Remove/graft hip bone lesion	5	$1,542.47	$717.00		$143.40
27080	Removal of tail bone	2	$1,542.47	$446.00		$89.20
27086	Remove hip foreign body	1	$400.87	$333.00		$66.60
27087	Remove hip foreign body	3	$1,281.58	$510.00		$102.00
27097	Revision of hip tendon	3	$1,542.47	$510.00		$102.00
27098	Transfer tendon to pelvis	3	$1,542.47	$510.00		$102.00
27100	Transfer of abdominal muscle	4	$2,539.24	$630.00		$126.00
27105	Transfer of spinal muscle	4	$2,539.24	$630.00		$126.00
27110	Transfer of iliopsoas muscle	4	$2,539.24	$630.00		$126.00
27111	Transfer of iliopsoas muscle	4	$2,539.24	$630.00		$126.00
27193	Treat pelvic ring fracture	1	$104.11	$104.11	Y	$20.82
27194	Treat pelvic ring fracture	2	$895.58	$446.00		$89.20
27202	Treat tail bone fracture	2	$2,312.35	$446.00		$89.20
27230	Treat thigh fracture	1	$104.11	$104.11	Y	$20.82
27238	Treat thigh fracture	1	$104.11	$104.11	Y	$20.82
27246	Treat thigh fracture	1	$104.11	$104.11	Y	$20.82
27250	Treat hip dislocation	1	$104.11	$104.11	Y	$20.82
27252	Treat hip dislocation	2	$895.58	$446.00		$89.20
27257	Treat hip dislocation	3	$895.58	$510.00		$102.00
27265	Treat hip dislocation	1	$104.11	$104.11	Y	$20.82
27266	Treat hip dislocation	2	$895.58	$446.00		$89.20
27275	Manipulation of hip joint	2	$895.58	$446.00		$89.20
27301	Drain thigh/knee lesion	3	$1,075.21	$510.00		$102.00
27305	Incise thigh tendon & fascia	2	$1,281.58	$446.00		$89.20
27306	Incision of thigh tendon	3	$1,281.58	$510.00		$102.00
27307	Incision of thigh tendons	3	$1,281.58	$510.00		$102.00
27310	Exploration of knee joint	4	$1,542.47	$630.00		$126.00
27315	Partial removal, thigh nerve	2	$1,093.20	$446.00		$89.20
27320	Partial removal, thigh nerve	2	$1,093.20	$446.00		$89.20
27323	Biopsy, thigh soft tissues	1	$400.87	$333.00		$66.60
27324	Biopsy, thigh soft tissues	1	$1,229.54	$333.00		$66.60
27327	Removal of thigh lesion	2	$1,229.54	$446.00		$89.20
27328	Removal of thigh lesion	3	$1,229.54	$510.00		$102.00
27329	Remove tumor, thigh/knee	4	$1,229.54	$630.00		$126.00
27330	Biopsy, knee joint lining	4	$1,542.47	$630.00		$126.00
27331	Explore/treat knee joint	4	$1,542.47	$630.00		$126.00
27332	Removal of knee cartilage	4	$1,542.47	$630.00		$126.00
27333	Removal of knee cartilage	4	$1,542.47	$630.00		$126.00
27334	Remove knee joint lining	4	$1,542.47	$630.00		$126.00
27335	Remove knee joint lining	4	$1,542.47	$630.00		$126.00
27340	Removal of kneecap bursa	3	$1,281.58	$510.00		$102.00
27345	Removal of knee cyst	4	$1,281.58	$630.00		$126.00
27347	Remove knee cyst	4	$1,281.58	$630.00		$126.00
27350	Removal of kneecap	4	$1,542.47	$630.00		$126.00
27355	Remove femur lesion	3	$1,542.47	$510.00		$102.00
27356	Remove femur lesion/graft	4	$1,542.47	$630.00		$126.00
27357	Remove femur lesion/graft	5	$1,542.47	$717.00		$143.40
27358	Remove femur lesion/fixation	5	$1,542.47	$717.00		$143.40
27360	Partial removal, leg bone(s)	5	$1,542.47	$717.00		$143.40

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
27372	Removal of foreign body	7	$1,229.54	$995.00		$199.00
27380	Repair of kneecap tendon	1	$1,281.58	$333.00		$66.60
27381	Repair/graft kneecap tendon	3	$1,281.58	$510.00		$102.00
27385	Repair of thigh muscle	3	$1,281.58	$510.00		$102.00
27386	Repair/graft of thigh muscle	3	$1,281.58	$510.00		$102.00
27390	Incision of thigh tendon	1	$1,281.58	$333.00		$66.60
27391	Incision of thigh tendons	2	$1,281.58	$446.00		$89.20
27392	Incision of thigh tendons	3	$1,281.58	$510.00		$102.00
27393	Lengthening of thigh tendon	2	$1,542.47	$446.00		$89.20
27394	Lengthening of thigh tendons	3	$1,542.47	$510.00		$102.00
27395	Lengthening of thigh tendons	3	$2,539.24	$510.00		$102.00
27396	Transplant of thigh tendon	3	$1,542.47	$510.00		$102.00
27397	Transplants of thigh tendons	3	$2,539.24	$510.00		$102.00
27400	Revise thigh muscles/tendons	3	$2,539.24	$510.00		$102.00
27403	Repair of knee cartilage	4	$1,542.47	$630.00		$126.00
27405	Repair of knee ligament	4	$2,539.24	$630.00		$126.00
27407	Repair of knee ligament	4	$4,055.26	$630.00		$126.00
27409	Repair of knee ligaments	4	$2,539.24	$630.00		$126.00
27418	Repair degenerated kneecap	3	$2,539.24	$510.00		$102.00
27420	Revision of unstable kneecap	3	$2,539.24	$510.00		$102.00
27422	Revision of unstable kneecap	7	$2,539.24	$995.00		$199.00
27424	Revision/removal of kneecap	3	$2,539.24	$510.00		$102.00
27425	Lat retinacular release open	7	$1,542.47	$995.00		$199.00
27427	Reconstruction, knee	3	$2,539.24	$510.00		$102.00
27428	Reconstruction, knee	4	$4,055.26	$630.00		$126.00
27429	Reconstruction, knee	4	$4,055.26	$630.00		$126.00
27430	Revision of thigh muscles	4	$2,539.24	$630.00		$126.00
27435	Incision of knee joint	4	$2,539.24	$630.00		$126.00
27437	Revise kneecap	4	$2,016.06	$630.00		$126.00
27438	Revise kneecap with implant	5	$2,903.02	$717.00		$143.40
27441	Revision of knee joint	5	$2,016.06	$717.00		$143.40
27442	Revision of knee joint	5	$2,016.06	$717.00		$143.40
27443	Revision of knee joint	5	$2,016.06	$717.00		$143.40
27496	Decompression of thigh/knee	5	$1,281.58	$717.00		$143.40
27497	Decompression of thigh/knee	3	$1,281.58	$510.00		$102.00
27498	Decompression of thigh/knee	3	$1,281.58	$510.00		$102.00
27499	Decompression of thigh/knee	3	$1,281.58	$510.00		$102.00
27500	Treatment of thigh fracture	1	$104.11	$104.11	Y	$20.82
27501	Treatment of thigh fracture	2	$104.11	$104.11	Y	$20.82
27502	Treatment of thigh fracture	2	$104.11	$104.11	Y	$20.82
27503	Treatment of thigh fracture	3	$104.11	$104.11	Y	$20.82
27508	Treatment of thigh fracture	1	$104.11	$104.11	Y	$20.82
27509	Treatment of thigh fracture	3	$1,580.03	$510.00		$102.00
27510	Treatment of thigh fracture	1	$104.11	$104.11	Y	$20.82
27516	Treat thigh fx growth plate	1	$104.11	$104.11	Y	$20.82
27517	Treat thigh fx growth plate	1	$104.11	$104.11	Y	$20.82
27520	Treat kneecap fracture	1	$104.11	$104.11	Y	$20.82
27530	Treat knee fracture	1	$104.11	$104.11	Y	$20.82
27532	Treat knee fracture	1	$104.11	$104.11	Y	$20.82
27538	Treat knee fracture(s)	1	$104.11	$104.11	Y	$20.82
27550	Treat knee dislocation	1	$104.11	$104.11	Y	$20.82
27552	Treat knee dislocation	1	$895.58	$333.00		$66.60
27560	Treat kneecap dislocation	1	$104.11	$104.11	Y	$20.82
27562	Treat kneecap dislocation	1	$895.58	$333.00		$66.60
27566	Treat kneecap dislocation	2	$2,312.35	$446.00		$89.20
27570	Fixation of knee joint	1	$895.58	$333.00		$66.60
27594	Amputation follow-up surgery	3	$1,281.58	$510.00		$102.00
27600	Decompression of lower leg	3	$1,281.58	$510.00		$102.00
27601	Decompression of lower leg	3	$1,281.58	$510.00		$102.00
27602	Decompression of lower leg	3	$1,281.58	$510.00		$102.00
27603	Drain lower leg lesion	2	$1,075.21	$446.00		$89.20
27604	Drain lower leg bursa	2	$1,281.58	$446.00		$89.20
27605	Incision of achilles tendon	1	$1,244.90	$333.00		$66.60
27606	Incision of achilles tendon	1	$1,281.58	$333.00		$66.60
27607	Treat lower leg bone lesion	2	$1,281.58	$446.00		$89.20
27610	Explore/treat ankle joint	2	$1,542.47	$446.00		$89.20
27612	Exploration of ankle joint	3	$1,542.47	$510.00		$102.00
27614	Biopsy lower leg soft tissue	2	$1,229.54	$446.00		$89.20
27615	Remove tumor, lower leg	3	$1,542.47	$510.00		$102.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
27618	Remove lower leg lesion	2	$920.58	$446.00		$89.20
27619	Remove lower leg lesion	3	$1,229.54	$510.00		$102.00
27620	Explore/treat ankle joint	4	$1,542.47	$630.00		$126.00
27625	Remove ankle joint lining	4	$1,542.47	$630.00		$126.00
27626	Remove ankle joint lining	4	$1,542.47	$630.00		$126.00
27630	Removal of tendon lesion	3	$1,281.58	$510.00		$102.00
27635	Remove lower leg bone lesion	3	$1,542.47	$510.00		$102.00
27637	Remove/graft leg bone lesion	3	$1,542.47	$510.00		$102.00
27638	Remove/graft leg bone lesion	3	$1,542.47	$510.00		$102.00
27640	Partial removal of tibia	2	$2,539.24	$446.00		$89.20
27641	Partial removal of fibula	2	$1,542.47	$446.00		$89.20
27647	Extensive ankle/heel surgery	3	$2,539.24	$510.00		$102.00
27650	Repair achilles tendon	3	$2,539.24	$510.00		$102.00
27652	Repair/graft achilles tendon	3	$4,055.26	$510.00		$102.00
27654	Repair of achilles tendon	3	$2,539.24	$510.00		$102.00
27656	Repair leg fascia defect	2	$1,281.58	$446.00		$89.20
27658	Repair of leg tendon, each	1	$1,281.58	$333.00		$66.60
27659	Repair of leg tendon, each	2	$1,281.58	$446.00		$89.20
27664	Repair of leg tendon, each	2	$1,281.58	$446.00		$89.20
27665	Repair of leg tendon, each	2	$1,542.47	$446.00		$89.20
27675	Repair lower leg tendons	2	$1,281.58	$446.00		$89.20
27676	Repair lower leg tendons	3	$1,542.47	$510.00		$102.00
27680	Release of lower leg tendon	3	$1,542.47	$510.00		$102.00
27681	Release of lower leg tendons	2	$1,542.47	$446.00		$89.20
27685	Revision of lower leg tendon	3	$1,542.47	$510.00		$102.00
27686	Revise lower leg tendons	3	$1,542.47	$510.00		$102.00
27687	Revision of calf tendon	3	$1,542.47	$510.00		$102.00
27690	Revise lower leg tendon	4	$2,539.24	$630.00		$126.00
27691	Revise lower leg tendon	4	$2,539.24	$630.00		$126.00
27692	Revise additional leg tendon	3	$2,539.24	$510.00		$102.00
27695	Repair of ankle ligament	2	$1,542.47	$446.00		$89.20
27696	Repair of ankle ligaments	2	$1,542.47	$446.00		$89.20
27698	Repair of ankle ligament	2	$1,542.47	$446.00		$89.20
27700	Revision of ankle joint	5	$2,016.06	$717.00		$143.40
27704	Removal of ankle implant	2	$1,281.58	$446.00		$89.20
27705	Incision of tibia	2	$2,539.24	$446.00		$89.20
27707	Incision of fibula	2	$1,281.58	$446.00		$89.20
27709	Incision of tibia & fibula	2	$1,542.47	$446.00		$89.20
27730	Repair of tibia epiphysis	2	$1,542.47	$446.00		$89.20
27732	Repair of fibula epiphysis	2	$1,542.47	$446.00		$89.20
27734	Repair lower leg epiphyses	2	$1,542.47	$446.00		$89.20
27740	Repair of leg epiphyses	2	$1,542.47	$446.00		$89.20
27742	Repair of leg epiphyses	2	$2,539.24	$446.00		$89.20
27745	Reinforce tibia	3	$4,055.26	$510.00		$102.00
27750	Treatment of tibia fracture	1	$104.11	$104.11	Y	$20.82
27752	Treatment of tibia fracture	1	$104.11	$104.11	Y	$20.82
27756	Treatment of tibia fracture	3	$1,580.03	$510.00		$102.00
27758	Treatment of tibia fracture	4	$2,312.35	$630.00		$126.00
27759	Treatment of tibia fracture	4	$3,472.68	$630.00		$126.00
27760	Treatment of ankle fracture	1	$104.11	$104.11	Y	$20.82
27762	Treatment of ankle fracture	1	$104.11	$104.11	Y	$20.82
27766	Treatment of ankle fracture	3	$2,312.35	$510.00		$102.00
27780	Treatment of fibula fracture	1	$104.11	$104.11	Y	$20.82
27781	Treatment of fibula fracture	1	$104.11	$104.11	Y	$20.82
27784	Treatment of fibula fracture	3	$2,312.35	$510.00		$102.00
27786	Treatment of ankle fracture	1	$104.11	$104.11	Y	$20.82
27788	Treatment of ankle fracture	1	$104.11	$104.11	Y	$20.82
27792	Treatment of ankle fracture	3	$2,312.35	$510.00		$102.00
27808	Treatment of ankle fracture	1	$104.11	$104.11	Y	$20.82
27810	Treatment of ankle fracture	1	$104.11	$104.11	Y	$20.82
27814	Treatment of ankle fracture	3	$2,312.35	$510.00		$102.00
27816	Treatment of ankle fracture	1	$104.11	$104.11	Y	$20.82
27818	Treatment of ankle fracture	1	$104.11	$104.11	Y	$20.82
27822	Treatment of ankle fracture	3	$2,312.35	$510.00		$102.00
27823	Treatment of ankle fracture	3	$3,472.68	$510.00		$102.00
27824	Treat lower leg fracture	1	$104.11	$104.11	Y	$20.82
27825	Treat lower leg fracture	2	$104.11	$104.11	Y	$20.82
27826	Treat lower leg fracture	3	$2,312.35	$510.00		$102.00
27827	Treat lower leg fracture	3	$3,472.68	$510.00		$102.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
27828	Treat lower leg fracture	4	$3,472.68	$630.00		$126.00
27829	Treat lower leg joint	2	$2,312.35	$446.00		$89.20
27830	Treat lower leg dislocation	1	$104.11	$104.11	Y	$20.82
27831	Treat lower leg dislocation	1	$104.11	$104.11	Y	$20.82
27832	Treat lower leg dislocation	2	$2,312.35	$446.00		$89.20
27840	Treat ankle dislocation	1	$104.11	$104.11	Y	$20.82
27842	Treat ankle dislocation	1	$895.58	$333.00		$66.60
27846	Treat ankle dislocation	3	$2,312.35	$510.00		$102.00
27848	Treat ankle dislocation	3	$2,312.35	$510.00		$102.00
27860	Fixation of ankle joint	1	$895.58	$333.00		$66.60
27870	Fusion of ankle joint, open	4	$4,055.26	$630.00		$126.00
27871	Fusion of tibiofibular joint	4	$4,055.26	$630.00		$126.00
27884	Amputation follow-up surgery	3	$1,281.58	$510.00		$102.00
27889	Amputation of foot at ankle	3	$1,542.47	$510.00		$102.00
27892	Decompression of leg	3	$1,281.58	$510.00		$102.00
27893	Decompression of leg	3	$1,281.58	$510.00		$102.00
27894	Decompression of leg	3	$1,281.58	$510.00		$102.00
28002	Treatment of foot infection	3	$1,281.58	$510.00		$102.00
28003	Treatment of foot infection	3	$1,281.58	$510.00		$102.00
28005	Treat foot bone lesion	3	$1,244.90	$510.00		$102.00
28008	Incision of foot fascia	3	$1,244.90	$510.00		$102.00
28011	Incision of toe tendons	3	$1,244.90	$510.00		$102.00
28020	Exploration of foot joint	2	$1,244.90	$446.00		$89.20
28022	Exploration of foot joint	2	$1,244.90	$446.00		$89.20
28024	Exploration of toe joint	2	$1,244.90	$446.00		$89.20
28030	Removal of foot nerve	4	$1,093.20	$630.00		$126.00
28035	Decompression of tibia nerve	4	$1,093.20	$630.00		$126.00
28043	Excision of foot lesion	2	$1,229.54	$446.00		$89.20
28045	Excision of foot lesion	3	$1,244.90	$510.00		$102.00
28046	Resection of tumor, foot	3	$1,244.90	$510.00		$102.00
28050	Biopsy of foot joint lining	2	$1,244.90	$446.00		$89.20
28052	Biopsy of foot joint lining	2	$1,244.90	$446.00		$89.20
28054	Biopsy of toe joint lining	2	$1,244.90	$446.00		$89.20
28060	Partial removal, foot fascia	2	$1,244.90	$446.00		$89.20
28062	Removal of foot fascia	3	$1,244.90	$510.00		$102.00
28070	Removal of foot joint lining	3	$1,244.90	$510.00		$102.00
28072	Removal of foot joint lining	3	$1,244.90	$510.00		$102.00
28080	Removal of foot lesion	3	$1,244.90	$510.00		$102.00
28086	Excise foot tendon sheath	2	$1,244.90	$446.00		$89.20
28088	Excise foot tendon sheath	2	$1,244.90	$446.00		$89.20
28090	Removal of foot lesion	3	$1,244.90	$510.00		$102.00
28092	Removal of toe lesions	3	$1,244.90	$510.00		$102.00
28100	Removal of ankle/heel lesion	2	$1,244.90	$446.00		$89.20
28102	Remove/graft foot lesion	3	$2,537.37	$510.00		$102.00
28103	Remove/graft foot lesion	3	$2,537.37	$510.00		$102.00
28104	Removal of foot lesion	2	$1,244.90	$446.00		$89.20
28106	Remove/graft foot lesion	3	$2,537.37	$510.00		$102.00
28107	Remove/graft foot lesion	3	$2,537.37	$510.00		$102.00
28108	Removal of toe lesions	2	$1,244.90	$446.00		$89.20
28110	Part removal of metatarsal	3	$1,244.90	$510.00		$102.00
28111	Part removal of metatarsal	3	$1,244.90	$510.00		$102.00
28112	Part removal of metatarsal	3	$1,244.90	$510.00		$102.00
28113	Part removal of metatarsal	3	$1,244.90	$510.00		$102.00
28114	Removal of metatarsal heads	3	$1,244.90	$510.00		$102.00
28116	Revision of foot	3	$1,244.90	$510.00		$102.00
28118	Removal of heel bone	4	$1,244.90	$630.00		$126.00
28119	Removal of heel spur	4	$1,244.90	$630.00		$126.00
28120	Part removal of ankle/heel	7	$1,244.90	$995.00		$199.00
28122	Partial removal of foot bone	3	$1,244.90	$510.00		$102.00
28126	Partial removal of toe	3	$1,244.90	$510.00		$102.00
28130	Removal of ankle bone	3	$1,244.90	$510.00		$102.00
28140	Removal of metatarsal	3	$1,244.90	$510.00		$102.00
28150	Removal of toe	3	$1,244.90	$510.00		$102.00
28153	Partial removal of toe	3	$1,244.90	$510.00		$102.00
28160	Partial removal of toe	3	$1,244.90	$510.00		$102.00
28171	Extensive foot surgery	3	$1,244.90	$510.00		$102.00
28173	Extensive foot surgery	3	$1,244.90	$510.00		$102.00
28175	Extensive foot surgery	3	$1,244.90	$510.00		$102.00
28192	Removal of foot foreign body	2	$920.58	$446.00		$89.20

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
28193	Removal of foot foreign body	4	$400.87	$400.87	Y	$80.17
28200	Repair of foot tendon	3	$1,244.90	$510.00		$102.00
28202	Repair/graft of foot tendon	3	$1,244.90	$510.00		$102.00
28208	Repair of foot tendon	3	$1,244.90	$510.00		$102.00
28210	Repair/graft of foot tendon	3	$2,537.37	$510.00		$102.00
28222	Release of foot tendons	1	$1,244.90	$333.00		$66.60
28225	Release of foot tendon	1	$1,244.90	$333.00		$66.60
28226	Release of foot tendons	1	$1,244.90	$333.00		$66.60
28234	Incision of foot tendon	2	$1,244.90	$446.00		$89.20
28238	Revision of foot tendon	3	$2,537.37	$510.00		$102.00
28240	Release of big toe	2	$1,244.90	$446.00		$89.20
28250	Revision of foot fascia	3	$1,244.90	$510.00		$102.00
28260	Release of midfoot joint	3	$1,244.90	$510.00		$102.00
28261	Revision of foot tendon	3	$1,244.90	$510.00		$102.00
28262	Revision of foot and ankle	4	$1,244.90	$630.00		$126.00
28264	Release of midfoot joint	1	$2,537.37	$333.00		$66.60
28270	Release of foot contracture	3	$1,244.90	$510.00		$102.00
28280	Fusion of toes	2	$1,244.90	$446.00		$89.20
28285	Repair of hammertoe	3	$1,244.90	$510.00		$102.00
28286	Repair of hammertoe	4	$1,244.90	$630.00		$126.00
28288	Partial removal of foot bone	3	$1,244.90	$510.00		$102.00
28289	Repair hallux rigidus	3	$1,244.90	$510.00		$102.00
28290	Correction of bunion	2	$1,729.40	$446.00		$89.20
28292	Correction of bunion	2	$1,729.40	$446.00		$89.20
28293	Correction of bunion	3	$1,729.40	$510.00		$102.00
28294	Correction of bunion	3	$1,729.40	$510.00		$102.00
28296	Correction of bunion	3	$1,729.40	$510.00		$102.00
28297	Correction of bunion	3	$1,729.40	$510.00		$102.00
28298	Correction of bunion	3	$1,729.40	$510.00		$102.00
28299	Correction of bunion	5	$1,729.40	$717.00		$143.40
28300	Incision of heel bone	2	$2,537.37	$446.00		$89.20
28302	Incision of ankle bone	2	$1,244.90	$446.00		$89.20
28304	Incision of midfoot bones	2	$2,537.37	$446.00		$89.20
28305	Incise/graft midfoot bones	3	$2,537.37	$510.00		$102.00
28306	Incision of metatarsal	4	$1,244.90	$630.00		$126.00
28307	Incision of metatarsal	4	$1,244.90	$630.00		$126.00
28308	Incision of metatarsal	2	$1,244.90	$446.00		$89.20
28309	Incision of metatarsals	4	$2,537.37	$630.00		$126.00
28310	Revision of big toe	3	$1,244.90	$510.00		$102.00
28312	Revision of toe	3	$1,244.90	$510.00		$102.00
28313	Repair deformity of toe	2	$1,244.90	$446.00		$89.20
28315	Removal of sesamoid bone	4	$1,244.90	$630.00		$126.00
28320	Repair of foot bones	4	$2,537.37	$630.00		$126.00
28322	Repair of metatarsals	4	$2,537.37	$630.00		$126.00
28340	Resect enlarged toe tissue	4	$1,244.90	$630.00		$126.00
28341	Resect enlarged toe	4	$1,244.90	$630.00		$126.00
28344	Repair extra toe(s)	4	$1,244.90	$630.00		$126.00
28345	Repair webbed toe(s)	4	$1,244.90	$630.00		$126.00
28400	Treatment of heel fracture	1	$104.11	$104.11	Y	$20.82
28405	Treatment of heel fracture	2	$104.11	$104.11	Y	$20.82
28406	Treatment of heel fracture	2	$1,580.03	$446.00		$89.20
28415	Treat heel fracture	3	$2,312.35	$510.00		$102.00
28420	Treat/graft heel fracture	4	$2,312.35	$630.00		$126.00
28435	Treatment of ankle fracture	2	$104.11	$104.11	Y	$20.82
28436	Treatment of ankle fracture	2	$1,580.03	$446.00		$89.20
28445	Treat ankle fracture	3	$2,312.35	$510.00		$102.00
28456	Treat midfoot fracture	2	$1,580.03	$446.00		$89.20
28465	Treat midfoot fracture, each	3	$2,312.35	$510.00		$102.00
28476	Treat metatarsal fracture	2	$1,580.03	$446.00		$89.20
28485	Treat metatarsal fracture	4	$2,312.35	$630.00		$126.00
28496	Treat big toe fracture	2	$1,580.03	$446.00		$89.20
28505	Treat big toe fracture	3	$2,312.35	$510.00		$102.00
28525	Treat toe fracture	3	$2,312.35	$510.00		$102.00
28531	Treat sesamoid bone fracture	3	$2,312.35	$510.00		$102.00
28545	Treat foot dislocation	1	$1,580.03	$333.00		$66.60
28546	Treat foot dislocation	2	$1,580.03	$446.00		$89.20
28555	Repair foot dislocation	2	$2,312.35	$446.00		$89.20
28575	Treat foot dislocation	1	$104.11	$104.11	Y	$20.82
28576	Treat foot dislocation	3	$1,580.03	$510.00		$102.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
28585	Repair foot dislocation	3	$2,312.35	$510.00		$102.00
28605	Treat foot dislocation	1	$104.11	$104.11	Y	$20.82
28606	Treat foot dislocation	2	$1,580.03	$446.00		$89.20
28615	Repair foot dislocation	3	$2,312.35	$510.00		$102.00
28635	Treat toe dislocation	1	$895.58	$333.00		$66.60
28636	Treat toe dislocation	3	$1,580.03	$510.00		$102.00
28645	Repair toe dislocation	3	$2,312.35	$510.00		$102.00
28665	Treat toe dislocation	1	$895.58	$333.00		$66.60
28666	Treat toe dislocation	3	$1,580.03	$510.00		$102.00
28675	Repair of toe dislocation	3	$2,312.35	$510.00		$102.00
28705	Fusion of foot bones	4	$2,537.37	$630.00		$126.00
28715	Fusion of foot bones	4	$2,537.37	$630.00		$126.00
28725	Fusion of foot bones	4	$2,537.37	$630.00		$126.00
28730	Fusion of foot bones	4	$2,537.37	$630.00		$126.00
28735	Fusion of foot bones	4	$2,537.37	$630.00		$126.00
28737	Revision of foot bones	5	$2,537.37	$717.00		$143.40
28740	Fusion of foot bones	4	$2,537.37	$630.00		$126.00
28750	Fusion of big toe joint	4	$2,537.37	$630.00		$126.00
28755	Fusion of big toe joint	4	$1,244.90	$630.00		$126.00
28760	Fusion of big toe joint	4	$2,537.37	$630.00		$126.00
28810	Amputation toe & metatarsal	2	$1,244.90	$446.00		$89.20
28820	Amputation of toe	2	$1,244.90	$446.00		$89.20
28825	Partial amputation of toe	2	$1,244.90	$446.00		$89.20
29800	Jaw arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29804	Jaw arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29805	Shoulder arthroscopy, dx	3	$1,762.08	$510.00		$102.00
29806	Shoulder arthroscopy/surgery	3	$2,773.72	$510.00		$102.00
29807	Shoulder arthroscopy/surgery	3	$2,773.72	$510.00		$102.00
29819	Shoulder arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29820	Shoulder arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29821	Shoulder arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29822	Shoulder arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29823	Shoulder arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29824	Shoulder arthroscopy/surgery	5	$1,762.08	$717.00		$143.40
29825	Shoulder arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29826	Shoulder arthroscopy/surgery	3	$2,773.72	$510.00		$102.00
29827	Arthroscop rotator cuff repr	5	$2,773.72	$717.00		$143.40
29830	Elbow arthroscopy	3	$1,762.08	$510.00		$102.00
29834	Elbow arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29835	Elbow arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29836	Elbow arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29837	Elbow arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29838	Elbow arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29840	Wrist arthroscopy	3	$1,762.08	$510.00		$102.00
29843	Wrist arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29844	Wrist arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29845	Wrist arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29846	Wrist arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29847	Wrist arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29848	Wrist endoscopy/surgery	9	$1,762.08	$1,339.00		$267.80
29850	Knee arthroscopy/surgery	4	$1,762.08	$630.00		$126.00
29851	Knee arthroscopy/surgery	4	$2,773.72	$630.00		$126.00
29855	Tibial arthroscopy/surgery	4	$2,773.72	$630.00		$126.00
29856	Tibial arthroscopy/surgery	4	$1,762.08	$630.00		$126.00
29860	Hip arthroscopy, dx	4	$1,762.08	$630.00		$126.00
29861	Hip arthroscopy/surgery	4	$1,762.08	$630.00		$126.00
29862	Hip arthroscopy/surgery	9	$2,773.72	$1,339.00		$267.80
29863	Hip arthroscopy/surgery	4	$2,773.72	$630.00		$126.00
29870	Knee arthroscopy, dx	3	$1,762.08	$510.00		$102.00
29871	Knee arthroscopy/drainage	3	$1,762.08	$510.00		$102.00
29873	Knee arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29874	Knee arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29875	Knee arthroscopy/surgery	4	$1,762.08	$630.00		$126.00
29876	Knee arthroscopy/surgery	4	$1,762.08	$630.00		$126.00
29877	Knee arthroscopy/surgery	4	$1,762.08	$630.00		$126.00
29879	Knee arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29880	Knee arthroscopy/surgery	4	$1,762.08	$630.00		$126.00
29881	Knee arthroscopy/surgery	4	$1,762.08	$630.00		$126.00
29882	Knee arthroscopy/surgery	3	$1,762.08	$510.00		$102.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
29883	Knee arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29884	Knee arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29885	Knee arthroscopy/surgery	3	$2,773.72	$510.00		$102.00
29886	Knee arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29887	Knee arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29888	Knee arthroscopy/surgery	3	$2,773.72	$510.00		$102.00
29889	Knee arthroscopy/surgery	3	$2,773.72	$510.00		$102.00
29891	Ankle arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29892	Ankle arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29893	Scope, plantar fasciotomy	9	$1,244.90	$1,244.90	Y	$248.98
29894	Ankle arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29895	Ankle arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29897	Ankle arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29898	Ankle arthroscopy/surgery	3	$1,762.08	$510.00		$102.00
29899	Ankle arthroscopy/surgery	3	$2,773.72	$510.00		$102.00
29900	Mcp joint arthroscopy, dx	3	$986.93	$510.00		$102.00
29901	Mcp joint arthroscopy, surg	3	$986.93	$510.00		$102.00
29902	Mcp joint arthroscopy, surg	3	$986.93	$510.00		$102.00
30115	Removal of nose polyp(s)	2	$1,012.48	$446.00		$89.20
30117	Removal of intranasal lesion	3	$1,012.48	$510.00		$102.00
30118	Removal of intranasal lesion	3	$1,425.30	$510.00		$102.00
30120	Revision of nose	1	$1,012.48	$333.00		$66.60
30125	Removal of nose lesion	2	$2,324.90	$446.00		$89.20
30130	Excise inferior turbinate	3	$1,012.48	$510.00		$102.00
30140	Resect inferior turbinate	2	$1,425.30	$446.00		$89.20
30150	Partial removal of nose	3	$2,324.90	$510.00		$102.00
30160	Removal of nose	4	$2,324.90	$630.00		$126.00
30220	Insert nasal septal button	3	$475.55	$475.55	Y	$95.11
30310	Remove nasal foreign body	1	$1,012.48	$333.00		$66.60
30320	Remove nasal foreign body	2	$1,012.48	$446.00		$89.20
30400	Reconstruction of nose	4	$2,324.90	$630.00		$126.00
30410	Reconstruction of nose	5	$2,324.90	$717.00		$143.40
30420	Reconstruction of nose	5	$2,324.90	$717.00		$143.40
30430	Revision of nose	3	$1,425.30	$510.00		$102.00
30435	Revision of nose	5	$2,324.90	$717.00		$143.40
30450	Revision of nose	7	$2,324.90	$995.00		$199.00
30460	Revision of nose	7	$2,324.90	$995.00		$199.00
30462	Revision of nose	9	$2,324.90	$1,339.00		$267.80
30465	Repair nasal stenosis	9	$2,324.90	$1,339.00		$267.80
30520	Repair of nasal septum	4	$1,425.30	$630.00		$126.00
30540	Repair nasal defect	5	$2,324.90	$717.00		$143.40
30545	Repair nasal defect	5	$2,324.90	$717.00		$143.40
30560	Release of nasal adhesions	2	$146.29	$146.29	Y	$29.26
30580	Repair upper jaw fistula	4	$2,324.90	$630.00		$126.00
30600	Repair mouth/nose fistula	4	$2,324.90	$630.00		$126.00
30620	Intranasal reconstruction	7	$2,324.90	$995.00		$199.00
30630	Repair nasal septum defect	7	$1,425.30	$995.00		$199.00
30801	Ablate inf turbinate, superf	1	$475.55	$333.00		$66.60
30802	Cauterization, inner nose	1	$475.55	$333.00		$66.60
30903	Control of nosebleed	1	$73.99	$73.99	Y	$14.80
30905	Control of nosebleed	1	$73.99	$73.99	Y	$14.80
30906	Repeat control of nosebleed	1	$73.99	$73.99	Y	$14.80
30915	Ligation, nasal sinus artery	2	$1,513.03	$446.00		$89.20
30920	Ligation, upper jaw artery	3	$1,513.03	$510.00		$102.00
30930	Ther fx, nasal inf turbinate	4	$1,012.48	$630.00		$126.00
31020	Exploration, maxillary sinus	2	$1,425.30	$446.00		$89.20
31030	Exploration, maxillary sinus	3	$2,324.90	$510.00		$102.00
31032	Explore sinus, remove polyps	4	$2,324.90	$630.00		$126.00
31050	Exploration, sphenoid sinus	2	$2,324.90	$446.00		$89.20
31051	Sphenoid sinus surgery	4	$2,324.90	$630.00		$126.00
31070	Exploration of frontal sinus	2	$1,425.30	$446.00		$89.20
31075	Exploration of frontal sinus	4	$2,324.90	$630.00		$126.00
31080	Removal of frontal sinus	4	$2,324.90	$630.00		$126.00
31081	Removal of frontal sinus	4	$2,324.90	$630.00		$126.00
31084	Removal of frontal sinus	4	$2,324.90	$630.00		$126.00
31085	Removal of frontal sinus	4	$2,324.90	$630.00		$126.00
31086	Removal of frontal sinus	4	$2,324.90	$630.00		$126.00
31087	Removal of frontal sinus	4	$2,324.90	$630.00		$126.00
31090	Exploration of sinuses	5	$2,324.90	$717.00		$143.40

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
31200	Removal of ethmoid sinus	2	$2,324.90	$446.00		$89.20
31201	Removal of ethmoid sinus	5	$2,324.90	$717.00		$143.40
31205	Removal of ethmoid sinus	3	$2,324.90	$510.00		$102.00
31233	Nasal/sinus endoscopy, dx	2	$86.41	$86.41	Y	$17.28
31235	Nasal/sinus endoscopy, dx	1	$931.27	$333.00		$66.60
31237	Nasal/sinus endoscopy, surg	2	$931.27	$446.00		$89.20
31238	Nasal/sinus endoscopy, surg	1	$931.27	$333.00		$66.60
31239	Nasal/sinus endoscopy, surg	4	$1,341.87	$630.00		$126.00
31240	Nasal/sinus endoscopy, surg	2	$931.27	$446.00		$89.20
31254	Revision of ethmoid sinus	3	$1,341.87	$510.00		$102.00
31255	Removal of ethmoid sinus	5	$1,341.87	$717.00		$143.40
31256	Exploration maxillary sinus	3	$1,341.87	$510.00		$102.00
31267	Endoscopy, maxillary sinus	3	$1,341.87	$510.00		$102.00
31276	Sinus endoscopy, surgical	3	$1,341.87	$510.00		$102.00
31287	Nasal/sinus endoscopy, surg	3	$1,341.87	$510.00		$102.00
31288	Nasal/sinus endoscopy, surg	3	$1,341.87	$510.00		$102.00
31300	Removal of larynx lesion	5	$1,425.30	$717.00		$143.40
31320	Diagnostic incision, larynx	2	$2,324.90	$446.00		$89.20
31400	Revision of larynx	2	$2,324.90	$446.00		$89.20
31420	Removal of epiglottis	2	$2,324.90	$446.00		$89.20
31510	Laryngoscopy with biopsy	2	$931.27	$446.00		$89.20
31511	Remove foreign body, larynx	2	$86.41	$86.41	Y	$17.28
31512	Removal of larynx lesion	2	$931.27	$446.00		$89.20
31513	Injection into vocal cord	2	$86.41	$86.41	Y	$17.28
31515	Laryngoscopy for aspiration	1	$931.27	$333.00		$66.60
31525	Dx laryngoscopy excl nb	1	$931.27	$333.00		$66.60
31526	Dx laryngoscopy w/oper scope	2	$1,341.87	$446.00		$89.20
31527	Laryngoscopy for treatment	1	$1,341.87	$333.00		$66.60
31528	Laryngoscopy and dilation	2	$931.27	$446.00		$89.20
31529	Laryngoscopy and dilation	2	$931.27	$446.00		$89.20
31530	Laryngoscopy w/fb removal	2	$1,341.87	$446.00		$89.20
31531	Laryngoscopy w/fb & op scope	3	$1,341.87	$510.00		$102.00
31535	Laryngoscopy w/biopsy	2	$1,341.87	$446.00		$89.20
31536	Laryngoscopy w/bx & op scope	3	$1,341.87	$510.00		$102.00
31540	Laryngoscopy w/exc of tumor	3	$1,341.87	$510.00		$102.00
31541	Larynscop w/tumr exc + scope	4	$1,341.87	$630.00		$126.00
31545	Remove vc lesion w/scope	4	$1,341.87	$630.00		$126.00
31546	Remove vc lesion scope/graft	4	$1,341.87	$630.00		$126.00
31560	Laryngoscop w/arytenoidectom	5	$1,341.87	$717.00		$143.40
31561	Larynscop, remve cart + scop	5	$1,341.87	$717.00		$143.40
31570	Laryngoscope w/vc inj	2	$931.27	$446.00		$89.20
31571	Laryngoscop w/vc inj + scope	2	$1,341.87	$446.00		$89.20
31576	Laryngoscopy with biopsy	2	$1,341.87	$446.00		$89.20
31577	Remove foreign body, larynx	2	$238.43	$238.43	Y	$47.69
31578	Removal of larynx lesion	2	$1,341.87	$446.00		$89.20
31580	Revision of larynx	5	$2,324.90	$717.00		$143.40
31582	Revision of larynx	5	$2,324.90	$717.00		$143.40
31588	Revision of larynx	5	$2,324.90	$717.00		$143.40
31590	Reinnervate larynx	5	$2,324.90	$717.00		$143.40
31595	Larynx nerve surgery	2	$2,324.90	$446.00		$89.20
31603	Incision of windpipe	1	$475.55	$333.00		$66.60
31611	Surgery/speech prosthesis	3	$1,425.30	$510.00		$102.00
31612	Puncture/clear windpipe	1	$1,425.30	$333.00		$66.60
31613	Repair windpipe opening	2	$1,425.30	$446.00		$89.20
31614	Repair windpipe opening	2	$2,324.90	$446.00		$89.20
31615	Visualization of windpipe	1	$577.99	$333.00		$66.60
31622	Dx bronchoscope/wash	1	$577.99	$333.00		$66.60
31623	Dx bronchoscope/brush	2	$577.99	$446.00		$89.20
31624	Dx bronchoscope/lavage	2	$577.99	$446.00		$89.20
31625	Bronchoscopy w/biopsy(s)	2	$577.99	$446.00		$89.20
31628	Bronchoscopy/lung bx, each	2	$577.99	$446.00		$89.20
31629	Bronchoscopy/needle bx, each	2	$577.99	$446.00		$89.20
31630	Bronchoscopy dilate/fx repr	2	$1,346.75	$446.00		$89.20
31631	Bronchoscopy, dilate w/stent	2	$1,346.75	$446.00		$89.20
31635	Bronchoscopy w/fb removal	2	$577.99	$446.00		$89.20
31636	Bronchoscopy, bronch stents	2	$1,346.75	$446.00		$89.20
31637	Bronchoscopy, stent add-on	1	$577.99	$333.00		$66.60
31638	Bronchoscopy, revise stent	2	$1,346.75	$446.00		$89.20
31640	Bronchoscopy w/tumor excise	2	$1,346.75	$446.00		$89.20

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
31641	Bronchoscopy, treat blockage	2	$1,346.75	$446.00		$89.20
31643	Diag bronchoscope/catheter	2	$577.99	$446.00		$89.20
31645	Bronchoscopy, clear airways	1	$577.99	$333.00		$66.60
31646	Bronchoscopy, reclear airway	1	$577.99	$333.00		$66.60
31656	Bronchoscopy, inj for x-ray	1	$577.99	$333.00		$66.60
31700	Insertion of airway catheter	1	$86.41	$86.41	Y	$17.28
31717	Bronchial brush biopsy	1	$238.43	$238.43	Y	$47.69
31720	Clearance of airways	1	$46.61	$46.61	Y	$9.32
31730	Intro, windpipe wire/tube	1	$238.43	$238.43	Y	$47.69
31750	Repair of windpipe	5	$2,324.90	$717.00		$143.40
31755	Repair of windpipe	2	$2,324.90	$446.00		$89.20
31820	Closure of windpipe lesion	1	$1,012.48	$333.00		$66.60
31825	Repair of windpipe defect	2	$1,425.30	$446.00		$89.20
31830	Revise windpipe scar	2	$1,425.30	$446.00		$89.20
32000	Drainage of chest	1	$224.20	$224.20	Y	$44.84
32400	Needle biopsy chest lining	1	$373.79	$333.00		$66.60
32405	Biopsy, lung or mediastinum	1	$373.79	$333.00		$66.60
32420	Puncture/clear lung	1	$224.20	$224.20	Y	$44.84
33010	Drainage of heart sac	2	$224.20	$224.20	Y	$44.84
33011	Repeat drainage of heart sac	2	$224.20	$224.20	Y	$44.84
33212	Insertion of pulse generator	3	$6,021.89	$510.00		$102.00
33213	Insertion of pulse generator	3	$6,908.16	$510.00		$102.00
33222	Revise pocket, pacemaker	2	$1,308.85	$446.00		$89.20
33223	Revise pocket, pacing-defib	2	$1,308.85	$446.00		$89.20
33233	Removal of pacemaker system	2	$1,444.39	$446.00		$89.20
35188	Repair blood vessel lesion	4	$2,336.80	$630.00		$126.00
35207	Repair blood vessel lesion	4	$2,336.80	$630.00		$126.00
35476	Repair venous blockage	9	$2,639.89	$1,339.00		$267.80
35875	Removal of clot in graft	9	$2,336.80	$1,339.00		$267.80
35876	Removal of clot in graft	9	$2,336.80	$1,339.00		$267.80
36260	Insertion of infusion pump	3	$1,752.02	$510.00		$102.00
36261	Revision of infusion pump	2	$1,752.02	$446.00		$89.20
36262	Removal of infusion pump	1	$1,397.11	$333.00		$66.60
36475	Endovenous rf, 1st vein	8	$2,131.38	$973.00		$194.60
36476	Endovenous rf, vein add-on	8	$2,131.38	$973.00		$194.60
36478	Endovenous laser, 1st vein	8	$1,513.03	$973.00		$194.60
36479	Endovenous laser vein addon	8	$1,513.03	$973.00		$194.60
36555	Insert non-tunnel cv cath	1	$540.67	$333.00		$66.60
36556	Insert non-tunnel cv cath	1	$540.67	$333.00		$66.60
36557	Insert tunneled cv cath	2	$1,397.11	$446.00		$89.20
36558	Insert tunneled cv cath	2	$1,397.11	$446.00		$89.20
36560	Insert tunneled cv cath	3	$1,752.02	$510.00		$102.00
36561	Insert tunneled cv cath	3	$1,752.02	$510.00		$102.00
36563	Insert tunneled cv cath	3	$1,752.02	$510.00		$102.00
36565	Insert tunneled cv cath	3	$1,752.02	$510.00		$102.00
36566	Insert tunneled cv cath	3	$1,752.02	$510.00		$102.00
36568	Insert picc cath	1	$540.67	$333.00		$66.60
36569	Insert picc cath	1	$540.67	$333.00		$66.60
36570	Insert picvad cath	3	$1,397.11	$510.00		$102.00
36571	Insert picvad cath	3	$1,397.11	$510.00		$102.00
36575	Repair tunneled cv cath	2	$540.67	$446.00		$89.20
36576	Repair tunneled cv cath	2	$540.67	$446.00		$89.20
36578	Replace tunneled cv cath	2	$1,397.11	$446.00		$89.20
36580	Replace cvad cath	1	$540.67	$333.00		$66.60
36581	Replace tunneled cv cath	2	$1,397.11	$446.00		$89.20
36582	Replace tunneled cv cath	3	$1,752.02	$510.00		$102.00
36583	Replace tunneled cv cath	3	$1,752.02	$510.00		$102.00
36584	Replace picc cath	1	$540.67	$333.00		$66.60
36585	Replace picvad cath	3	$1,397.11	$510.00		$102.00
36589	Removal tunneled cv cath	1	$540.67	$333.00		$66.60
36590	Removal tunneled cv cath	1	$540.67	$333.00		$66.60
36640	Insertion catheter, artery	1	$1,752.02	$333.00		$66.60
36800	Insertion of cannula	3	$1,814.26	$510.00		$102.00
36810	Insertion of cannula	3	$1,814.26	$510.00		$102.00
36815	Insertion of cannula	3	$1,814.26	$510.00		$102.00
36818	AV fuse, upper arm, cephalic	3	$2,336.80	$510.00		$102.00
36819	Av fuse, uppr arm, basilic	3	$2,336.80	$510.00		$102.00
36820	Av fusion/forearm vein	3	$2,336.80	$510.00		$102.00
36821	Av fusion direct any site	3	$2,336.80	$510.00		$102.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
36825	Artery-vein autograft	4	$2,336.80	$630.00		$126.00
36830	Artery-vein nonautograft	4	$2,336.80	$630.00		$126.00
36831	Open thrombect av fistula	9	$2,336.80	$1,339.00		$267.80
36832	Av fistula revision, open	4	$2,336.80	$630.00		$126.00
36833	Av fistula revision	4	$2,336.80	$630.00		$126.00
36834	Repair a-v aneurysm	3	$2,336.80	$510.00		$102.00
36835	Artery to vein shunt	4	$1,814.26	$630.00		$126.00
36860	External cannula declotting	2	$126.87	$126.87	Y	$25.37
36861	Cannula declotting	3	$1,814.26	$510.00		$102.00
36870	Percut thrombect av fistula	9	$1,908.11	$1,339.00		$267.80
37205	Transcath IV stent, percutan	9	$4,067.31	$1,339.00		$267.80
37206	Transcath IV stent/perc, add	1	$4,067.31	$333.00		$66.60
37500	Endoscopy ligate perf veins	3	$2,131.38	$510.00		$102.00
37607	Ligation of a-v fistula	3	$1,513.03	$510.00		$102.00
37609	Temporal artery procedure	2	$920.58	$446.00		$89.20
37650	Revision of major vein	2	$1,513.03	$446.00		$89.20
37700	Revise leg vein	2	$2,131.38	$446.00		$89.20
37718	Ligate/strip short leg vein	3	$2,131.38	$510.00		$102.00
37722	Ligate/strip long leg vein	3	$2,131.38	$510.00		$102.00
37735	Removal of leg veins/lesion	3	$2,131.38	$510.00		$102.00
37760	Ligation, leg veins, open	3	$1,513.03	$510.00		$102.00
37780	Revision of leg vein	3	$1,513.03	$510.00		$102.00
37785	Ligate/divide/excise vein	3	$1,513.03	$510.00		$102.00
37790	Penile venous occlusion	3	$2,031.13	$510.00		$102.00
38300	Drainage, lymph node lesion	1	$672.04	$333.00		$66.60
38305	Drainage, lymph node lesion	2	$1,075.21	$446.00		$89.20
38308	Incision of lymph channels	2	$1,315.18	$446.00		$89.20
38500	Biopsy/removal, lymph nodes	2	$1,315.18	$446.00		$89.20
38505	Needle biopsy, lymph nodes	1	$234.21	$234.21	Y	$46.84
38510	Biopsy/removal, lymph nodes	2	$1,315.18	$446.00		$89.20
38520	Biopsy/removal, lymph nodes	2	$1,315.18	$446.00		$89.20
38525	Biopsy/removal, lymph nodes	2	$1,315.18	$446.00		$89.20
38530	Biopsy/removal, lymph nodes	2	$1,315.18	$446.00		$89.20
38542	Explore deep node(s), neck	2	$2,285.28	$446.00		$89.20
38550	Removal, neck/armpit lesion	3	$1,315.18	$510.00		$102.00
38555	Removal, neck/armpit lesion	4	$1,315.18	$630.00		$126.00
38570	Laparoscopy, lymph node biop	9	$2,678.23	$1,339.00		$267.80
38571	Laparoscopy, lymphadenectomy	9	$4,363.07	$1,339.00		$267.80
38572	Laparoscopy, lymphadenectomy	9	$2,678.23	$1,339.00		$267.80
38740	Remove armpit lymph nodes	2	$2,285.28	$446.00		$89.20
38745	Remove armpit lymph nodes	4	$2,285.28	$630.00		$126.00
38760	Remove groin lymph nodes	2	$1,315.18	$446.00		$89.20
40500	Partial excision of lip	2	$1,012.48	$446.00		$89.20
40510	Partial excision of lip	2	$1,425.30	$446.00		$89.20
40520	Partial excision of lip	2	$1,012.48	$446.00		$89.20
40525	Reconstruct lip with flap	2	$1,425.30	$446.00		$89.20
40527	Reconstruct lip with flap	2	$1,425.30	$446.00		$89.20
40530	Partial removal of lip	2	$1,425.30	$446.00		$89.20
40650	Repair lip	3	$475.55	$475.55	Y	$95.11
40652	Repair lip	3	$475.55	$475.55	Y	$95.11
40654	Repair lip	3	$475.55	$475.55	Y	$95.11
40700	Repair cleft lip/nasal	7	$2,324.90	$995.00		$199.00
40701	Repair cleft lip/nasal	7	$2,324.90	$995.00		$199.00
40720	Repair cleft lip/nasal	7	$2,324.90	$995.00		$199.00
40761	Repair cleft lip/nasal	3	$2,324.90	$510.00		$102.00
40801	Drainage of mouth lesion	2	$475.55	$446.00		$89.20
40814	Excise/repair mouth lesion	2	$1,012.48	$446.00		$89.20
40816	Excision of mouth lesion	2	$1,425.30	$446.00		$89.20
40818	Excise oral mucosa for graft	1	$146.29	$146.29	Y	$29.26
40819	Excise lip or cheek fold	1	$475.55	$333.00		$66.60
40831	Repair mouth laceration	1	$475.55	$333.00		$66.60
40840	Reconstruction of mouth	2	$1,425.30	$446.00		$89.20
40842	Reconstruction of mouth	3	$1,425.30	$510.00		$102.00
40843	Reconstruction of mouth	3	$1,425.30	$510.00		$102.00
40844	Reconstruction of mouth	5	$2,324.90	$717.00		$143.40
40845	Reconstruction of mouth	5	$2,324.90	$717.00		$143.40
41005	Drainage of mouth lesion	1	$146.29	$146.29	Y	$29.26
41006	Drainage of mouth lesion	1	$1,425.30	$333.00		$66.60
41007	Drainage of mouth lesion	1	$1,012.48	$333.00		$66.60

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
41008	Drainage of mouth lesion	1	$1,012.48	$333.00		$66.60
41009	Drainage of mouth lesion	1	$146.29	$146.29	Y	$29.26
41010	Incision of tongue fold	1	$475.55	$333.00		$66.60
41015	Drainage of mouth lesion	1	$146.29	$146.29	Y	$29.26
41016	Drainage of mouth lesion	1	$475.55	$333.00		$66.60
41017	Drainage of mouth lesion	1	$475.55	$333.00		$66.60
41018	Drainage of mouth lesion	1	$475.55	$333.00		$66.60
41112	Excision of tongue lesion	2	$1,012.48	$446.00		$89.20
41113	Excision of tongue lesion	2	$1,012.48	$446.00		$89.20
41114	Excision of tongue lesion	2	$1,425.30	$446.00		$89.20
41116	Excision of mouth lesion	1	$1,012.48	$333.00		$66.60
41120	Partial removal of tongue	5	$1,425.30	$717.00		$143.40
41250	Repair tongue laceration	2	$146.29	$146.29	Y	$29.26
41251	Repair tongue laceration	2	$146.29	$146.29	Y	$29.26
41252	Repair tongue laceration	2	$475.55	$446.00		$89.20
41500	Fixation of tongue	1	$1,425.30	$333.00		$66.60
41510	Tongue to lip surgery	1	$1,012.48	$333.00		$66.60
41520	Reconstruction, tongue fold	2	$475.55	$446.00		$89.20
41800	Drainage of gum lesion	1	$91.22	$91.22	Y	$18.24
41827	Excision of gum lesion	2	$1,425.30	$446.00		$89.20
42000	Drainage mouth roof lesion	2	$146.29	$146.29	Y	$29.26
42107	Excision lesion, mouth roof	2	$1,425.30	$446.00		$89.20
42120	Remove palate/lesion	4	$2,324.90	$630.00		$126.00
42140	Excision of uvula	2	$475.55	$446.00		$89.20
42145	Repair palate, pharynx/uvula	5	$1,425.30	$717.00		$143.40
42180	Repair palate	1	$146.29	$146.29	Y	$29.26
42182	Repair palate	2	$2,324.90	$446.00		$89.20
42200	Reconstruct cleft palate	5	$2,324.90	$717.00		$143.40
42205	Reconstruct cleft palate	5	$2,324.90	$717.00		$143.40
42210	Reconstruct cleft palate	5	$2,324.90	$717.00		$143.40
42215	Reconstruct cleft palate	7	$2,324.90	$995.00		$199.00
42220	Reconstruct cleft palate	5	$2,324.90	$717.00		$143.40
42226	Lengthening of palate	5	$2,324.90	$717.00		$143.40
42235	Repair palate	5	$1,012.48	$717.00		$143.40
42260	Repair nose to lip fistula	4	$1,425.30	$630.00		$126.00
42300	Drainage of salivary gland	1	$1,012.48	$333.00		$66.60
42305	Drainage of salivary gland	2	$1,012.48	$446.00		$89.20
42310	Drainage of salivary gland	1	$146.29	$146.29	Y	$29.26
42320	Drainage of salivary gland	1	$146.29	$146.29	Y	$29.26
42340	Removal of salivary stone	2	$1,012.48	$446.00		$89.20
42405	Biopsy of salivary gland	2	$1,012.48	$446.00		$89.20
42408	Excision of salivary cyst	3	$1,012.48	$510.00		$102.00
42409	Drainage of salivary cyst	3	$1,012.48	$510.00		$102.00
42410	Excise parotid gland/lesion	3	$2,324.90	$510.00		$102.00
42415	Excise parotid gland/lesion	7	$2,324.90	$995.00		$199.00
42420	Excise parotid gland/lesion	7	$2,324.90	$995.00		$199.00
42425	Excise parotid gland/lesion	7	$2,324.90	$995.00		$199.00
42440	Excise submaxillary gland	3	$2,324.90	$510.00		$102.00
42450	Excise sublingual gland	2	$1,425.30	$446.00		$89.20
42500	Repair salivary duct	3	$1,425.30	$510.00		$102.00
42505	Repair salivary duct	4	$2,324.90	$630.00		$126.00
42507	Parotid duct diversion	3	$2,324.90	$510.00		$102.00
42508	Parotid duct diversion	4	$2,324.90	$630.00		$126.00
42509	Parotid duct diversion	4	$2,324.90	$630.00		$126.00
42510	Parotid duct diversion	4	$2,324.90	$630.00		$126.00
42600	Closure of salivary fistula	1	$1,012.48	$333.00		$66.60
42665	Ligation of salivary duct	7	$1,425.30	$995.00		$199.00
42700	Drainage of tonsil abscess	1	$146.29	$146.29	Y	$29.26
42720	Drainage of throat abscess	1	$1,012.48	$333.00		$66.60
42725	Drainage of throat abscess	2	$2,324.90	$446.00		$89.20
42802	Biopsy of throat	1	$1,012.48	$333.00		$66.60
42804	Biopsy of upper nose/throat	1	$1,012.48	$333.00		$66.60
42806	Biopsy of upper nose/throat	2	$1,425.30	$446.00		$89.20
42808	Excise pharynx lesion	2	$1,012.48	$446.00		$89.20
42810	Excision of neck cyst	3	$1,425.30	$510.00		$102.00
42815	Excision of neck cyst	5	$2,324.90	$717.00		$143.40
42820	Remove tonsils and adenoids	3	$1,401.87	$510.00		$102.00
42821	Remove tonsils and adenoids	5	$1,401.87	$717.00		$143.40
42825	Removal of tonsils	4	$1,401.87	$630.00		$126.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
42826	Removal of tonsils	4	$1,401.87	$630.00		$126.00
42830	Removal of adenoids	4	$1,401.87	$630.00		$126.00
42831	Removal of adenoids	4	$1,401.87	$630.00		$126.00
42835	Removal of adenoids	4	$1,401.87	$630.00		$126.00
42836	Removal of adenoids	4	$1,401.87	$630.00		$126.00
42860	Excision of tonsil tags	3	$1,401.87	$510.00		$102.00
42870	Excision of lingual tonsil	3	$1,401.87	$510.00		$102.00
42890	Partial removal of pharynx	7	$2,324.90	$995.00		$199.00
42892	Revision of pharyngeal walls	7	$2,324.90	$995.00		$199.00
42900	Repair throat wound	1	$475.55	$333.00		$66.60
42950	Reconstruction of throat	2	$1,425.30	$446.00		$89.20
42955	Surgical opening of throat	2	$1,425.30	$446.00		$89.20
42960	Control throat bleeding	1	$73.99	$73.99	Y	$14.80
42962	Control throat bleeding	2	$2,324.90	$446.00		$89.20
42972	Control nose/throat bleeding	3	$1,012.48	$510.00		$102.00
43200	Esophagus endoscopy	1	$511.30	$333.00		$66.60
43201	Esoph scope w/submucous inj	1	$511.30	$333.00		$66.60
43202	Esophagus endoscopy, biopsy	1	$511.30	$333.00		$66.60
43204	Esoph scope w/sclerosis inj	1	$511.30	$333.00		$66.60
43205	Esophagus endoscopy/ligation	1	$511.30	$333.00		$66.60
43215	Esophagus endoscopy	1	$511.30	$333.00		$66.60
43216	Esophagus endoscopy/lesion	1	$511.30	$333.00		$66.60
43217	Esophagus endoscopy	1	$511.30	$333.00		$66.60
43219	Esophagus endoscopy	1	$1,395.84	$333.00		$66.60
43220	Esoph endoscopy, dilation	1	$511.30	$333.00		$66.60
43226	Esoph endoscopy, dilation	1	$511.30	$333.00		$66.60
43227	Esoph endoscopy, repair	2	$511.30	$446.00		$89.20
43228	Esoph endoscopy, ablation	2	$1,695.69	$446.00		$89.20
43231	Esoph endoscopy w/us exam	2	$511.30	$446.00		$89.20
43232	Esoph endoscopy w/us fn bx	2	$511.30	$446.00		$89.20
43234	Upper gi endoscopy, exam	1	$511.30	$333.00		$66.60
43235	Uppr gi endoscopy, diagnosis	1	$511.30	$333.00		$66.60
43236	Uppr gi scope w/submuc inj	2	$511.30	$446.00		$89.20
43237	Endoscopic us exam, esoph	2	$511.30	$446.00		$89.20
43238	Uppr gi endoscopy w/us fn bx	2	$511.30	$446.00		$89.20
43239	Upper gi endoscopy, biopsy	2	$511.30	$446.00		$89.20
43240	Esoph endoscope w/drain cyst	2	$511.30	$446.00		$89.20
43241	Upper gi endoscopy with tube	2	$511.30	$446.00		$89.20
43242	Uppr gi endoscopy w/us fn bx	2	$511.30	$446.00		$89.20
43243	Upper gi endoscopy & inject	2	$511.30	$446.00		$89.20
43244	Upper gi endoscopy/ligation	2	$511.30	$446.00		$89.20
43245	Uppr gi scope dilate strictr	2	$511.30	$446.00		$89.20
43246	Place gastrostomy tube	2	$511.30	$446.00		$89.20
43247	Operative upper gi endoscopy	2	$511.30	$446.00		$89.20
43248	Uppr gi endoscopy/guide wire	2	$511.30	$446.00		$89.20
43249	Esoph endoscopy, dilation	2	$511.30	$446.00		$89.20
43250	Upper gi endoscopy/tumor	2	$511.30	$446.00		$89.20
43251	Operative upper gi endoscopy	2	$511.30	$446.00		$89.20
43255	Operative upper gi endoscopy	2	$511.30	$446.00		$89.20
43256	Uppr gi endoscopy w/stent	3	$1,395.84	$510.00		$102.00
43258	Operative upper gi endoscopy	3	$511.30	$510.00		$102.00
43259	Endoscopic ultrasound exam	3	$511.30	$510.00		$102.00
43260	Endo cholangiopancreatograph	2	$1,219.48	$446.00		$89.20
43261	Endo cholangiopancreatograph	2	$1,219.48	$446.00		$89.20
43262	Endo cholangiopancreatograph	2	$1,219.48	$446.00		$89.20
43263	Endo cholangiopancreatograph	2	$1,219.48	$446.00		$89.20
43264	Endo cholangiopancreatograph	2	$1,219.48	$446.00		$89.20
43265	Endo cholangiopancreatograph	2	$1,219.48	$446.00		$89.20
43267	Endo cholangiopancreatograph	2	$1,219.48	$446.00		$89.20
43268	Endo cholangiopancreatograph	2	$1,395.84	$446.00		$89.20
43269	Endo cholangiopancreatograph	2	$1,395.84	$446.00		$89.20
43271	Endo cholangiopancreatograph	2	$1,219.48	$446.00		$89.20
43272	Endo cholangiopancreatograph	2	$1,219.48	$446.00		$89.20
43450	Dilate esophagus	1	$327.05	$327.05	Y	$65.41
43453	Dilate esophagus	1	$327.05	$327.05	Y	$65.41
43456	Dilate esophagus	2	$327.05	$327.05	Y	$65.41
43458	Dilate esophagus	2	$327.05	$327.05	Y	$65.41
43600	Biopsy of stomach	1	$511.30	$333.00		$66.60
43653	Laparoscopy, gastrostomy	9	$2,678.23	$1,339.00		$267.80

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
43750	Place gastrostomy tube	2	$511.30	$446.00		$89.20
43760	Change gastrostomy tube	1	$144.22	$144.22	Y	$28.84
43761	Reposition gastrostomy tube	1	$448.45	$333.00		$66.60
43870	Repair stomach opening	1	$511.30	$333.00		$66.60
44100	Biopsy of bowel	1	$511.30	$333.00		$66.60
44312	Revision of ileostomy	1	$1,308.85	$333.00		$66.60
44340	Revision of colostomy	3	$1,308.85	$510.00		$102.00
44360	Small bowel endoscopy	2	$577.83	$446.00		$89.20
44361	Small bowel endoscopy/biopsy	2	$577.83	$446.00		$89.20
44363	Small bowel endoscopy	2	$577.83	$446.00		$89.20
44364	Small bowel endoscopy	2	$577.83	$446.00		$89.20
44365	Small bowel endoscopy	2	$577.83	$446.00		$89.20
44366	Small bowel endoscopy	2	$577.83	$446.00		$89.20
44369	Small bowel endoscopy	2	$577.83	$446.00		$89.20
44370	Small bowel endoscopy/stent	9	$1,395.84	$1,339.00		$267.80
44372	Small bowel endoscopy	2	$577.83	$446.00		$89.20
44373	Small bowel endoscopy	2	$577.83	$446.00		$89.20
44376	Small bowel endoscopy	2	$577.83	$446.00		$89.20
44377	Small bowel endoscopy/biopsy	2	$577.83	$446.00		$89.20
44378	Small bowel endoscopy	2	$577.83	$446.00		$89.20
44379	Sbowel endoscope w/stent	9	$1,395.84	$1,339.00		$267.80
44380	Small bowel endoscopy	1	$577.83	$333.00		$66.60
44382	Small bowel endoscopy	1	$577.83	$333.00		$66.60
44383	Ileoscopy w/stent	9	$1,395.84	$1,339.00		$267.80
44385	Endoscopy of bowel pouch	1	$542.53	$333.00		$66.60
44386	Endoscopy, bowel pouch/biop	1	$542.53	$333.00		$66.60
44388	Colonoscopy	1	$542.53	$333.00		$66.60
44389	Colonoscopy with biopsy	1	$542.53	$333.00		$66.60
44390	Colonoscopy for foreign body	1	$542.53	$333.00		$66.60
44391	Colonoscopy for bleeding	1	$542.53	$333.00		$66.60
44392	Colonoscopy & polypectomy	1	$542.53	$333.00		$66.60
44393	Colonoscopy, lesion removal	1	$542.53	$333.00		$66.60
44394	Colonoscopy w/snare	1	$542.53	$333.00		$66.60
44397	Colonoscopy w/stent	1	$1,395.84	$333.00		$66.60
45000	Drainage of pelvic abscess	1	$301.42	$301.42	Y	$60.28
45005	Drainage of rectal abscess	2	$792.64	$446.00		$89.20
45020	Drainage of rectal abscess	2	$792.64	$446.00		$89.20
45100	Biopsy of rectum	1	$1,368.50	$333.00		$66.60
45108	Removal of anorectal lesion	2	$1,368.50	$446.00		$89.20
45150	Excision of rectal stricture	2	$1,368.50	$446.00		$89.20
45160	Excision of rectal lesion	2	$1,368.50	$446.00		$89.20
45170	Excision of rectal lesion	2	$1,368.50	$446.00		$89.20
45190	Destruction, rectal tumor	9	$1,368.50	$1,339.00		$267.80
45305	Proctosigmoidoscopy w/bx	1	$527.15	$333.00		$66.60
45307	Proctosigmoidoscopy fb	1	$1,261.19	$333.00		$66.60
45308	Proctosigmoidoscopy removal	1	$527.15	$333.00		$66.60
45309	Proctosigmoidoscopy removal	1	$527.15	$333.00		$66.60
45315	Proctosigmoidoscopy removal	1	$527.15	$333.00		$66.60
45317	Proctosigmoidoscopy bleed	1	$527.15	$333.00		$66.60
45320	Proctosigmoidoscopy ablate	1	$1,261.19	$333.00		$66.60
45321	Proctosigmoidoscopy volvul	1	$1,261.19	$333.00		$66.60
45327	Proctosigmoidoscopy w/stent	1	$1,395.84	$333.00		$66.60
45331	Sigmoidoscopy and biopsy	1	$295.48	$295.48	Y	$59.10
45332	Sigmoidoscopy w/fb removal	1	$295.48	$295.48	Y	$59.10
45333	Sigmoidoscopy & polypectomy	1	$527.15	$333.00		$66.60
45334	Sigmoidoscopy for bleeding	1	$527.15	$333.00		$66.60
45335	Sigmoidoscopy w/submuc inj	1	$295.48	$295.48	Y	$59.10
45337	Sigmoidoscopy & decompress	1	$295.48	$295.48	Y	$59.10
45338	Sigmoidoscopy w/tumr remove	1	$527.15	$333.00		$66.60
45339	Sigmoidoscopy w/ablate tumr	1	$527.15	$333.00		$66.60
45340	Sig w/balloon dilation	1	$527.15	$333.00		$66.60
45341	Sigmoidoscopy w/ultrasound	1	$527.15	$333.00		$66.60
45342	Sigmoidoscopy w/us guide bx	1	$527.15	$333.00		$66.60
45345	Sigmoidoscopy w/stent	1	$1,395.84	$333.00		$66.60
45355	Surgical colonoscopy	1	$542.53	$333.00		$66.60
45378	Diagnostic colonoscopy	2	$542.53	$446.00		$89.20
45379	Colonoscopy w/fb removal	2	$542.53	$446.00		$89.20
45380	Colonoscopy and biopsy	2	$542.53	$446.00		$89.20
45381	Colonoscopy, submucous inj	2	$542.53	$446.00		$89.20

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
45382	Colonoscopy/control bleeding	2	$542.53	$446.00		$89.20
45383	Lesion removal colonoscopy	2	$542.53	$446.00		$89.20
45384	Lesion remove colonoscopy	2	$542.53	$446.00		$89.20
45385	Lesion removal colonoscopy	2	$542.53	$446.00		$89.20
45386	Colonoscopy dilate stricture	2	$542.53	$446.00		$89.20
45387	Colonoscopy w/stent	1	$1,395.84	$333.00		$66.60
45391	Colonoscopy w/endoscope us	2	$542.53	$446.00		$89.20
45392	Colonoscopy w/endoscopic fnb	2	$542.53	$446.00		$89.20
45500	Repair of rectum	2	$1,368.50	$446.00		$89.20
45505	Repair of rectum	2	$1,811.98	$446.00		$89.20
45560	Repair of rectocele	2	$1,811.98	$446.00		$89.20
45900	Reduction of rectal prolapse	1	$301.42	$301.42	Y	$60.28
45905	Dilation of anal sphincter	1	$1,368.50	$333.00		$66.60
45910	Dilation of rectal narrowing	1	$1,368.50	$333.00		$66.60
45915	Remove rectal obstruction	1	$301.42	$301.42	Y	$60.28
45990	Surg dx exam, anorcctal	2	$301.42	$301.42	Y	$60.28
46020	Placement of seton	3	$1,368.50	$510.00		$102.00
46030	Removal of rectal marker	1	$301.42	$301.42	Y	$60.28
46040	Incision of rectal abscess	3	$1,368.50	$510.00		$102.00
46045	Incision of rectal abscess	2	$1,368.50	$446.00		$89.20
46050	Incision of anal abscess	1	$301.42	$301.42	Y	$60.28
46060	Incision of rectal abscess	2	$1,368.50	$446.00		$89.20
46080	Incision of anal sphincter	3	$1,368.50	$510.00		$102.00
46200	Removal of anal fissure	2	$1,368.50	$446.00		$89.20
46210	Removal of anal crypt	2	$1,368.50	$446.00		$89.20
46211	Removal of anal crypts	2	$1,368.50	$446.00		$89.20
46220	Removal of anal tag	1	$1,368.50	$333.00		$66.60
46230	Removal of anal tags	1	$1,368.50	$333.00		$66.60
46250	Hemorrhoidectomy	3	$1,368.50	$510.00		$102.00
46255	Hemorrhoidectomy	3	$1,368.50	$510.00		$102.00
46257	Remove hemorrhoids & fissure	3	$1,368.50	$510.00		$102.00
46258	Remove hemorrhoids & fistula	3	$1,368.50	$510.00		$102.00
46260	Hemorrhoidectomy	3	$1,368.50	$510.00		$102.00
46261	Remove hemorrhoids & fissure	4	$1,368.50	$630.00		$126.00
46262	Remove hemorrhoids & fistula	4	$1,368.50	$630.00		$126.00
46270	Removal of anal fistula	3	$1,368.50	$510.00		$102.00
46275	Removal of anal fistula	3	$1,368.50	$510.00		$102.00
46280	Removal of anal fistula	4	$1,368.50	$630.00		$126.00
46285	Removal of anal fistula	1	$1,368.50	$333.00		$66.60
46288	Repair anal fistula	4	$1,368.50	$630.00		$126.00
46608	Anoscopy, remove for body	1	$527.15	$333.00		$66.60
46610	Anoscopy, remove lesion	1	$1,261.19	$333.00		$66.60
46611	Anoscopy	1	$527.15	$333.00		$66.60
46612	Anoscopy, remove lesions	1	$1,261.19	$333.00		$66.60
46615	Anoscopy	2	$1,261.19	$446.00		$89.20
46700	Repair of anal stricture	3	$1,368.50	$510.00		$102.00
46706	Repr of anal fistula w/glue	1	$1,811.98	$333.00		$66.60
46750	Repair of anal sphincter	3	$2,292.31	$510.00		$102.00
46753	Reconstruction of anus	3	$1,368.50	$510.00		$102.00
46754	Removal of suture from anus	2	$1,368.50	$446.00		$89.20
46760	Repair of anal sphincter	2	$2,292.31	$446.00		$89.20
46761	Repair of anal sphincter	3	$2,292.31	$510.00		$102.00
46762	Implant artificial sphincter	7	$2,292.31	$995.00		$199.00
46917	Laser surgery, anal lesions	1	$1,266.73	$333.00		$66.60
46922	Excision of anal lesion(s)	1	$1,266.73	$333.00		$66.60
46924	Destruction, anal lesion(s)	1	$1,266.73	$333.00		$66.60
46937	Cryotherapy of rectal lesion	2	$1,368.50	$446.00		$89.20
46938	Cryotherapy of rectal lesion	2	$1,811.98	$446.00		$89.20
46946	Ligation of hemorrhoids	1	$792.64	$333.00		$66.60
46947	Hemorrhoidopexy by stapling	7	$1,811.98	$995.00		$199.00
47000	Needle biopsy of liver	1	$373.79	$333.00		$66.60
47510	Insert catheter, bile duct	2	$1,197.26	$446.00		$89.20
47511	Insert bile duct drain	9	$1,197.26	$1,197.26	Y	$239.45
47525	Change bile duct catheter	1	$709.19	$333.00		$66.60
47530	Revise/reinsert bile tube	1	$709.19	$333.00		$66.60
47552	Biliary endoscopy thru skin	2	$1,197.26	$446.00		$89.20
47553	Biliary endoscopy thru skin	3	$1,197.26	$510.00		$102.00
47554	Biliary endoscopy thru skin	3	$1,197.26	$510.00		$102.00
47555	Biliary endoscopy thru skin	3	$1,197.26	$510.00		$102.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
47556	Biliary endoscopy thru skin	9	$1,197.26	$1,197.26	Y	$239.45
47560	Laparoscopy w/cholangio	3	$1,965.65	$510.00		$102.00
47561	Laparo w/cholangio/biopsy	3	$1,965.65	$510.00		$102.00
47630	Remove bile duct stone	3	$1,197.26	$510.00		$102.00
48102	Needle biopsy, pancreas	1	$373.79	$333.00		$66.60
49080	Puncture, peritoneal cavity	2	$224.20	$224.20	Y	$44.84
49081	Removal of abdominal fluid	2	$224.20	$224.20	Y	$44.84
49085	Remove abdomen foreign body	2	$1,364.94	$446.00		$89.20
49180	Biopsy, abdominal mass	1	$373.79	$333.00		$66.60
49250	Excision of umbilicus	4	$1,364.94	$630.00		$126.00
49320	Diag laparo separate proc	3	$1,965.65	$510.00		$102.00
49321	Laparoscopy, biopsy	4	$1,965.65	$630.00		$126.00
49322	Laparoscopy, aspiration	4	$1,965.65	$630.00		$126.00
49419	Insrt abdom cath for chemotx	1	$1,814.26	$333.00		$66.60
49420	Insert abdom drain, temp	1	$1,798.88	$333.00		$66.60
49421	Insert abdom drain, perm	1	$1,798.88	$333.00		$66.60
49422	Remove perm cannula/catheter	1	$1,444.39	$333.00		$66.60
49426	Revise abdomen-venous shunt	2	$1,364.94	$446.00		$89.20
49495	Rpr ing hernia baby, reduc	4	$1,794.16	$630.00		$126.00
49496	Rpr ing hernia baby, blocked	4	$1,794.16	$630.00		$126.00
49500	Rpr ing hernia, init, reduce	4	$1,794.16	$630.00		$126.00
49501	Rpr ing hernia, init blocked	9	$1,794.16	$1,339.00		$267.80
49505	Prp i/hern init reduc > 5 yr	4	$1,794.16	$630.00		$126.00
49507	Prp i/hern init block > 5 yr	9	$1,794.16	$1,339.00		$267.80
49520	Rerepair ing hernia, reduce	7	$1,794.16	$995.00		$199.00
49521	Rerepair ing hernia, blocked	9	$1,794.16	$1,339.00		$267.80
49525	Repair ing hernia, sliding	4	$1,794.16	$630.00		$126.00
49540	Repair lumbar hernia	2	$1,794.16	$446.00		$89.20
49550	Rpr rem hernia, init, reduce	5	$1,794.16	$717.00		$143.40
49553	Rpr fem hernia, init blocked	9	$1,794.16	$1,339.00		$267.80
49555	Rerepair fem hernia, reduce	5	$1,794.16	$717.00		$143.40
49557	Rerepair fem hernia, blocked	9	$1,794.16	$1,339.00		$267.80
49560	Rpr ventral hern init, reduc	4	$1,794.16	$630.00		$126.00
49561	Rpr ventral hern init, block	9	$1,794.16	$1,339.00		$267.80
49565	Rerepair ventrl hern, reduce	4	$1,794.16	$630.00		$126.00
49566	Rerepair ventrl hern, block	9	$1,794.16	$1,339.00		$267.80
49568	Hernia repair w/mesh	7	$1,794.16	$995.00		$199.00
49570	Rpr epigastric hern, reduce	4	$1,794.16	$630.00		$126.00
49572	Rpr epigastric hern, blocked	9	$1,794.16	$1,339.00		$267.80
49580	Rpr umbil hern, reduc < 5 yr	4	$1,794.16	$630.00		$126.00
49582	Rpr umbil hern, block < 5 yr	9	$1,794.16	$1,339.00		$267.80
49585	Rpr umbil hern, reduc > 5 yr	4	$1,794.16	$630.00		$126.00
49587	Rpr umbil hern, block > 5 yr	9	$1,794.16	$1,339.00		$267.80
49590	Repair spigelian hernia	3	$1,794.16	$510.00		$102.00
49600	Repair umbilical lesion	4	$1,794.16	$630.00		$126.00
49650	Laparo hernia repair initial	4	$2,678.23	$630.00		$126.00
49651	Laparo hernia repair recur	7	$2,678.23	$995.00		$199.00
50200	Biopsy of kidney	1	$373.79	$333.00		$66.60
50390	Drainage of kidney lesion	1	$373.79	$333.00		$66.60
50392	Insert kidney drain	1	$1,186.49	$333.00		$66.60
50393	Insert ureteral tube	1	$1,186.49	$333.00		$66.60
50395	Create passage to kidney	1	$1,186.49	$333.00		$66.60
50396	Measure kidney pressure	1	$130.24	$130.24	Y	$26.05
50398	Change kidney tube	1	$448.45	$333.00		$66.60
50551	Kidney endoscopy	1	$414.39	$333.00		$66.60
50553	Kidney endoscopy	1	$1,186.49	$333.00		$66.60
50555	Kidney endoscopy & biopsy	1	$414.39	$333.00		$66.60
50557	Kidney endoscopy & treatment	1	$1,468.37	$333.00		$66.60
50561	Kidney endoscopy & treatment	1	$1,186.49	$333.00		$66.60
50688	Change of ureter tube/stent	1	$448.45	$333.00		$66.60
50947	Laparo new ureter/bladder	9	$2,678.23	$1,339.00		$267.80
50948	Laparo new ureter/bladder	9	$2,678.23	$1,339.00		$267.80
50951	Endoscopy of ureter	1	$414.39	$333.00		$66.60
50953	Endoscopy of ureter	1	$414.39	$333.00		$66.60
50955	Ureter endoscopy & biopsy	1	$1,186.49	$333.00		$66.60
50957	Ureter endoscopy & treatment	1	$1,186.49	$333.00		$66.60
50961	Ureter endoscopy & treatment	1	$1,186.49	$333.00		$66.60
50970	Ureter endoscopy	1	$414.39	$333.00		$66.60
50972	Ureter endoscopy & catheter	1	$414.39	$333.00		$66.60

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
50974	Ureter endoscopy & biopsy	1	$1,186.49	$333.00		$66.60
50976	Ureter endoscopy & treatment	1	$1,186.49	$333.00		$66.60
50980	Ureter endoscopy & treatment	1	$1,186.49	$333.00		$66.60
51010	Drainage of bladder	1	$1,122.28	$333.00		$66.60
51020	Incise & treat bladder	4	$1,468.37	$630.00		$126.00
51030	Incise & treat bladder	4	$1,468.37	$630.00		$126.00
51040	Incise & drain bladder	4	$1,468.37	$630.00		$126.00
51045	Incise bladder/drain ureter	4	$414.39	$414.39	Y	$82.88
51050	Removal of bladder stone	4	$1,468.37	$630.00		$126.00
51065	Remove ureter calculus	4	$1,468.37	$630.00		$126.00
51080	Drainage of bladder abscess	1	$1,075.21	$333.00		$66.60
51500	Removal of bladder cyst	4	$1,794.16	$630.00		$126.00
51520	Removal of bladder lesion	4	$1,468.37	$630.00		$126.00
51710	Change of bladder tube	1	$448.45	$333.00		$66.60
51715	Endoscopic injection/implant	3	$1,760.18	$510.00		$102.00
51726	Complex cystometrogram	1	$219.66	$219.66	Y	$43.93
51772	Urethra pressure profile	1	$130.24	$130.24	Y	$26.05
51785	Anal/urinary muscle study	1	$66.75	$66.75	Y	$13.35
51880	Repair of bladder opening	1	$1,468.37	$333.00		$66.60
51992	Laparo sling operation	5	$2,678.23	$717.00		$143.40
52000	Cystoscopy	1	$414.39	$333.00		$66.60
52001	Cystoscopy, removal of clots	2	$414.39	$414.39	Y	$82.88
52005	Cystoscopy & ureter catheter	2	$1,186.49	$446.00		$89.20
52007	Cystoscopy and biopsy	2	$1,186.49	$446.00		$89.20
52010	Cystoscopy & duct catheter	2	$414.39	$414.39	Y	$82.88
52204	Cystoscopy	2	$1,186.49	$446.00		$89.20
52214	Cystoscopy and treatment	2	$1,468.37	$446.00		$89.20
52224	Cystoscopy and treatment	2	$1,468.37	$446.00		$89.20
52234	Cystoscopy and treatment	2	$1,468.37	$446.00		$89.20
52235	Cystoscopy and treatment	3	$1,468.37	$510.00		$102.00
52240	Cystoscopy and treatment	3	$1,468.37	$510.00		$102.00
52250	Cystoscopy and radiotracer	4	$1,468.37	$630.00		$126.00
52260	Cystoscopy and treatment	2	$1,186.49	$446.00		$89.20
52270	Cystoscopy & revise urethra	2	$1,186.49	$446.00		$89.20
52275	Cystoscopy & revise urethra	2	$1,186.49	$446.00		$89.20
52276	Cystoscopy and treatment	3	$1,186.49	$510.00		$102.00
52277	Cystoscopy and treatment	2	$1,468.37	$446.00		$89.20
52281	Cystoscopy and treatment	2	$1,186.49	$446.00		$89.20
52282	Cystoscopy, implant stent	9	$2,160.59	$1,339.00		$267.80
52283	Cystoscopy and treatment	2	$1,186.49	$446.00		$89.20
52285	Cystoscopy and treatment	2	$1,186.49	$446.00		$89.20
52290	Cystoscopy and treatment	2	$1,186.49	$446.00		$89.20
52300	Cystoscopy and treatment	2	$1,186.49	$446.00		$89.20
52301	Cystoscopy and treatment	3	$1,186.49	$510.00		$102.00
52305	Cystoscopy and treatment	2	$1,186.49	$446.00		$89.20
52310	Cystoscopy and treatment	2	$414.39	$414.39	Y	$82.88
52315	Cystoscopy and treatment	2	$1,186.49	$446.00		$89.20
52317	Remove bladder stone	1	$1,468.37	$333.00		$66.60
52318	Remove bladder stone	2	$1,468.37	$446.00		$89.20
52320	Cystoscopy and treatment	5	$1,468.37	$717.00		$143.40
52325	Cystoscopy, stone removal	4	$1,468.37	$630.00		$126.00
52327	Cystoscopy, inject material	2	$1,468.37	$446.00		$89.20
52330	Cystoscopy and treatment	2	$1,468.37	$446.00		$89.20
52332	Cystoscopy and treatment	2	$1,468.37	$446.00		$89.20
52334	Create passage to kidney	3	$1,468.37	$510.00		$102.00
52341	Cysto w/ureter stricture tx	3	$1,468.37	$510.00		$102.00
52342	Cysto w/up stricture tx	3	$1,468.37	$510.00		$102.00
52343	Cysto w/renal stricture tx	3	$1,468.37	$510.00		$102.00
52344	Cysto/uretero, stricture tx	3	$1,468.37	$510.00		$102.00
52345	Cysto/uretero w/up stricture	3	$1,468.37	$510.00		$102.00
52346	Cystouretero w/renal strict	3	$1,468.37	$510.00		$102.00
52351	Cystouretero & or pyeloscope	3	$1,186.49	$510.00		$102.00
52352	Cystouretero w/stone remove	4	$1,468.37	$630.00		$126.00
52353	Cystouretero w/lithotripsy	4	$2,160.59	$630.00		$126.00
52354	Cystouretero w/biopsy	4	$1,468.37	$630.00		$126.00
52355	Cystouretero w/excise tumor	4	$1,468.37	$630.00		$126.00
52400	Cystouretero w/congen repr	3	$1,468.37	$510.00		$102.00
52402	Cystourethro cut ejacul duct	3	$1,468.37	$510.00		$102.00
52450	Incision of prostate	3	$1,468.37	$510.00		$102.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
52500	Revision of bladder neck	3	$1,468.37	$510.00		$102.00
52510	Dilation prostatic urethra	3	$1,186.49	$510.00		$102.00
52601	Prostatectomy (turp)	4	$2,160.59	$630.00		$126.00
52606	Control postop bleeding	1	$1,468.37	$333.00		$66.60
52612	Prostatectomy, first stage	2	$2,160.59	$446.00		$89.20
52614	Prostatectomy, second stage	1	$2,160.59	$333.00		$66.60
52620	Remove residual prostate	1	$2,160.59	$333.00		$66.60
52630	Remove prostate regrowth	2	$2,160.59	$446.00		$89.20
52640	Relieve bladder contracture	2	$1,468.37	$446.00		$89.20
52647	Laser surgery of prostate	9	$2,642.55	$1,339.00		$267.80
52648	Laser surgery of prostate	9	$2,642.55	$1,339.00		$267.80
52700	Drainage of prostate abscess	2	$1,468.37	$446.00		$89.20
53000	Incision of urethra	1	$1,139.54	$333.00		$66.60
53010	Incision of urethra	1	$1,139.54	$333.00		$66.60
53020	Incision of urethra	1	$1,139.54	$333.00		$66.60
53040	Drainage of urethra abscess	2	$1,139.54	$446.00		$89.20
53080	Drainage of urinary leakage	3	$1,139.54	$510.00		$102.00
53200	Biopsy of urethra	1	$1,139.54	$333.00		$66.60
53210	Removal of urethra	5	$1,760.18	$717.00		$143.40
53215	Removal of urethra	5	$1,139.54	$717.00		$143.40
53220	Treatment of urethra lesion	2	$1,760.18	$446.00		$89.20
53230	Removal of urethra lesion	2	$1,760.18	$446.00		$89.20
53235	Removal of urethra lesion	3	$1,139.54	$510.00		$102.00
53240	Surgery for urethra pouch	2	$1,760.18	$446.00		$89.20
53250	Removal of urethra gland	2	$1,139.54	$446.00		$89.20
53260	Treatment of urethra lesion	2	$1,139.54	$446.00		$89.20
53265	Treatment of urethra lesion	2	$1,139.54	$446.00		$89.20
53270	Removal of urethra gland	2	$1,139.54	$446.00		$89.20
53275	Repair of urethra defect	2	$1,139.54	$446.00		$89.20
53400	Revise urethra, stage 1	3	$1,760.18	$510.00		$102.00
53405	Revise urethra, stage 2	2	$1,760.18	$446.00		$89.20
53410	Reconstruction of urethra	2	$1,760.18	$446.00		$89.20
53420	Reconstruct urethra, stage 1	3	$1,760.18	$510.00		$102.00
53425	Reconstruct urethra, stage 2	2	$1,760.18	$446.00		$89.20
53430	Reconstruction of urethra	2	$1,760.18	$446.00		$89.20
53431	Reconstruct urethra/bladder	2	$1,760.18	$446.00		$89.20
53440	Male sling procedure	2	$4,885.49	$446.00		$89.20
53442	Remove/revise male sling	1	$1,760.18	$333.00		$66.60
53444	Insert tandem cuff	2	$4,885.49	$446.00		$89.20
53445	Insert uro/ves nck sphincter	1	$8,354.29	$333.00		$66.60
53446	Remove uro sphincter	1	$1,760.18	$333.00		$66.60
53447	Remove/replace ur sphincter	1	$8,354.29	$333.00		$66.60
53449	Repair uro sphincter	1	$1,760.18	$333.00		$66.60
53450	Revision of urethra	1	$1,760.18	$333.00		$66.60
53460	Revision of urethra	1	$1,139.54	$333.00		$66.60
53502	Repair of urethra injury	2	$1,139.54	$446.00		$89.20
53505	Repair of urethra injury	2	$1,760.18	$446.00		$89.20
53510	Repair of urethra injury	2	$1,139.54	$446.00		$89.20
53515	Repair of urethra injury	2	$1,760.18	$446.00		$89.20
53520	Repair of urethra defect	2	$1,760.18	$446.00		$89.20
53605	Dilate urethra stricture	2	$1,186.49	$446.00		$89.20
53665	Dilation of urethra	1	$1,139.54	$333.00		$66.60
54000	Slitting of prepuce	2	$1,139.54	$446.00		$89.20
54001	Slitting of prepuce	2	$1,139.54	$446.00		$89.20
54015	Drain penis lesion	4	$1,075.21	$630.00		$126.00
54057	Laser surg, penis lesion(s)	1	$1,091.87	$333.00		$66.60
54060	Excision of penis lesion(s)	1	$1,091.87	$333.00		$66.60
54065	Destruction, penis lesion(s)	1	$1,266.73	$333.00		$66.60
54100	Biopsy of penis	1	$920.58	$333.00		$66.60
54105	Biopsy of penis	1	$1,229.54	$333.00		$66.60
54110	Treatment of penis lesion	2	$2,031.13	$446.00		$89.20
54111	Treat penis lesion, graft	2	$2,031.13	$446.00		$89.20
54112	Treat penis lesion, graft	2	$2,031.13	$446.00		$89.20
54115	Treatment of penis lesion	1	$1,075.21	$333.00		$66.60
54120	Partial removal of penis	2	$2,031.13	$446.00		$89.20
54150	Circumcision	1	$1,276.68	$333.00		$66.60
54152	Circumcision	1	$1,276.68	$333.00		$66.60
54160	Circumcision	2	$1,276.68	$446.00		$89.20
54161	Circumcision	2	$1,276.68	$446.00		$89.20

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
54162	Lysis penil circumic lesion	2	$1,276.68	$446.00		$89.20
54163	Repair of circumcision	2	$1,276.68	$446.00		$89.20
54164	Frenulotomy of penis	2	$1,276.68	$446.00		$89.20
54205	Treatment of penis lesion	4	$2,031.13	$630.00		$126.00
54220	Treatment of penis lesion	1	$130.24	$130.24	Y	$26.05
54300	Revision of penis	3	$2,031.13	$510.00		$102.00
54304	Revision of penis	3	$2,031.13	$510.00		$102.00
54308	Reconstruction of urethra	3	$2,031.13	$510.00		$102.00
54312	Reconstruction of urethra	3	$2,031.13	$510.00		$102.00
54316	Reconstruction of urethra	3	$2,031.13	$510.00		$102.00
54318	Reconstruction of urethra	3	$2,031.13	$510.00		$102.00
54322	Reconstruction of urethra	3	$2,031.13	$510.00		$102.00
54324	Reconstruction of urethra	3	$2,031.13	$510.00		$102.00
54326	Reconstruction of urethra	3	$2,031.13	$510.00		$102.00
54328	Revise penis/urethra	3	$2,031.13	$510.00		$102.00
54340	Secondary urethral surgery	3	$2,031.13	$510.00		$102.00
54344	Secondary urethral surgery	3	$2,031.13	$510.00		$102.00
54348	Secondary urethral surgery	3	$2,031.13	$510.00		$102.00
54352	Reconstruct urethra/penis	3	$2,031.13	$510.00		$102.00
54360	Penis plastic surgery	3	$2,031.13	$510.00		$102.00
54380	Repair penis	3	$2,031.13	$510.00		$102.00
54385	Repair penis	3	$2,031.13	$510.00		$102.00
54400	Insert semi-rigid prosthesis	3	$4,885.49	$510.00		$102.00
54401	Insert self-contd prosthesis	3	$8,354.29	$510.00		$102.00
54405	Insert multi-comp penis pros	3	$8,354.29	$510.00		$102.00
54406	Remove muti-comp penis pros	3	$2,031.13	$510.00		$102.00
54408	Repair multi-comp penis pros	3	$2,031.13	$510.00		$102.00
54410	Remove/replace penis prosth	3	$8,354.29	$510.00		$102.00
54415	Remove self-contd penis pros	3	$2,031.13	$510.00		$102.00
54416	Remv/repl penis contain pros	3	$8,354.29	$510.00		$102.00
54420	Revision of penis	4	$2,031.13	$630.00		$126.00
54435	Revision of penis	4	$2,031.13	$630.00		$126.00
54440	Repair of penis	4	$2,031.13	$630.00		$126.00
54450	Preputial stretching	1	$219.66	$219.66	Y	$43.93
54500	Biopsy of testis	1	$631.61	$333.00		$66.60
54505	Biopsy of testis	1	$1,459.20	$333.00		$66.60
54512	Excise lesion testis	2	$1,459.20	$446.00		$89.20
54520	Removal of testis	3	$1,459.20	$510.00		$102.00
54522	Orchiectomy, partial	3	$1,459.20	$510.00		$102.00
54530	Removal of testis	4	$1,794.16	$630.00		$126.00
54550	Exploration for testis	4	$1,794.16	$630.00		$126.00
54600	Reduce testis torsion	4	$1,459.20	$630.00		$126.00
54620	Suspension of testis	3	$1,459.20	$510.00		$102.00
54640	Suspension of testis	4	$1,794.16	$630.00		$126.00
54660	Revision of testis	2	$1,459.20	$446.00		$89.20
54670	Repair testis injury	3	$1,459.20	$510.00		$102.00
54680	Relocation of testis(es)	3	$1,459.20	$510.00		$102.00
54690	Laparoscopy, orchiectomy	9	$2,678.23	$1,339.00		$267.80
54700	Drainage of scrotum	2	$1,459.20	$446.00		$89.20
54800	Biopsy of epididymis	1	$128.41	$128.41	Y	$25.68
54820	Exploration of epididymis	1	$1,459.20	$333.00		$66.60
54830	Remove epididymis lesion	3	$1,459.20	$510.00		$102.00
54840	Remove epididymis lesion	4	$1,459.20	$630.00		$126.00
54860	Removal of epididymis	3	$1,459.20	$510.00		$102.00
54861	Removal of epididymis	4	$1,459.20	$630.00		$126.00
54900	Fusion of spermatic ducts	4	$1,459.20	$630.00		$126.00
54901	Fusion of spermatic ducts	4	$1,459.20	$630.00		$126.00
55040	Removal of hydrocele	3	$1,794.16	$510.00		$102.00
55041	Removal of hydroceles	5	$1,794.16	$717.00		$143.40
55060	Repair of hydrocele	4	$1,459.20	$630.00		$126.00
55100	Drainage of scrotum abscess	1	$672.04	$333.00		$66.60
55110	Explore scrotum	2	$1,459.20	$446.00		$89.20
55120	Removal of scrotum lesion	2	$1,459.20	$446.00		$89.20
55150	Removal of scrotum	1	$1,459.20	$333.00		$66.60
55175	Revision of scrotum	1	$1,459.20	$333.00		$66.60
55180	Revision of scrotum	2	$1,459.20	$446.00		$89.20
55200	Incision of sperm duct	2	$1,459.20	$446.00		$89.20
55250	Removal of sperm duct(s)	2	$1,459.20	$446.00		$89.20
55400	Repair of sperm duct	1	$1,459.20	$333.00		$66.60

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
55500	Removal of hydrocele	3	$1,459.20	$510.00		$102.00
55520	Removal of sperm cord lesion	4	$1,459.20	$630.00		$126.00
55530	Revise spermatic cord veins	4	$1,459.20	$630.00		$126.00
55535	Revise spermatic cord veins	4	$1,794.16	$630.00		$126.00
55540	Revise hernia & sperm veins	5	$1,794.16	$717.00		$143.40
55550	Laparo ligate spermatic vein	9	$2,678.23	$1,339.00		$267.80
55680	Remove sperm pouch lesion	1	$1,459.20	$333.00		$66.60
55700	Biopsy of prostate	2	$368.64	$368.64	Y	$73.73
55705	Biopsy of prostate	2	$368.64	$368.64	Y	$73.73
55720	Drainage of prostate abscess	1	$1,468.37	$333.00		$66.60
55725	Drainage of prostate abscess	2	$1,468.37	$446.00		$89.20
55859	Percut/needle insert, pros	9	$2,160.59	$1,339.00		$267.80
55873	Cryoablate prostate	9	$6,637.03	$1,339.00		$267.80
56440	Surgery for vulva lesion	2	$1,262.49	$446.00		$89.20
56441	Lysis of labial lesion(s)	1	$910.70	$333.00		$66.60
56515	Destroy vulva lesion/s compl	3	$1,266.73	$510.00		$102.00
56620	Partial removal of vulva	5	$1,769.04	$717.00		$143.40
56625	Complete removal of vulva	7	$1,769.04	$995.00		$199.00
56700	Partial removal of hymen	1	$1,262.49	$333.00		$66.60
56720	Incision of hymen	1	$910.70	$333.00		$66.60
56740	Remove vagina gland lesion	3	$1,262.49	$510.00		$102.00
56800	Repair of vagina	3	$1,262.49	$510.00		$102.00
56810	Repair of perineum	5	$1,262.49	$717.00		$143.40
57000	Exploration of vagina	1	$910.70	$333.00		$66.60
57010	Drainage of pelvic abscess	2	$910.70	$446.00		$89.20
57020	Drainage of pelvic fluid	2	$426.33	$426.33	Y	$85.27
57023	I& d vag hematoma, non-ob	1	$1,075.21	$333.00		$66.60
57065	Destroy vag lesions, complex	1	$1,262.49	$333.00		$66.60
57105	Biopsy of vagina	2	$1,262.49	$446.00		$89.20
57130	Remove vagina lesion	2	$1,262.49	$446.00		$89.20
57135	Remove vagina lesion	2	$1,262.49	$446.00		$89.20
57155	Insert uteri tandems/ovoids	2	$426.33	$426.33	Y	$85.27
57180	Treat vaginal bleeding	1	$184.05	$184.05	Y	$36.81
57200	Repair of vagina	1	$1,262.49	$333.00		$66.60
57210	Repair vagina/perineum	2	$1,262.49	$446.00		$89.20
57220	Revision of urethra	3	$2,639.04	$510.00		$102.00
57230	Repair of urethral lesion	3	$1,769.04	$510.00		$102.00
57240	Repair bladder & vagina	5	$1,769.04	$717.00		$143.40
57250	Repair rectum & vagina	5	$1,769.04	$717.00		$143.40
57260	Repair of vagina	5	$1,769.04	$717.00		$143.40
57265	Extensive repair of vagina	7	$2,639.04	$995.00		$199.00
57268	Repair of bowel bulge	3	$1,769.04	$510.00		$102.00
57288	Repair bladder defect	5	$2,639.04	$717.00		$143.40
57289	Repair bladder & vagina	5	$1,769.04	$717.00		$143.40
57291	Construction of vagina	5	$1,769.04	$717.00		$143.40
57300	Repair rectum-vagina fistula	3	$1,769.04	$510.00		$102.00
57400	Dilation of vagina	2	$1,262.49	$446.00		$89.20
57410	Pelvic examination	2	$910.70	$446.00		$89.20
57415	Remove vaginal foreign body	2	$1,262.49	$446.00		$89.20
57513	Laser surgery of cervix	2	$910.70	$446.00		$89.20
57520	Conization of cervix	2	$1,262.49	$446.00		$89.20
57522	Conization of cervix	2	$1,769.04	$446.00		$89.20
57530	Removal of cervix	3	$1,769.04	$510.00		$102.00
57550	Removal of residual cervix	3	$1,769.04	$510.00		$102.00
57556	Remove cervix, repair bowel	5	$2,639.04	$717.00		$143.40
57700	Revision of cervix	1	$1,262.49	$333.00		$66.60
57720	Revision of cervix	3	$1,262.49	$510.00		$102.00
57820	D& c of residual cervix	3	$1,093.36	$510.00		$102.00
58120	Dilation and curettage	2	$1,093.36	$446.00		$89.20
58145	Myomectomy vag method	5	$1,769.04	$717.00		$143.40
58346	Insert heyman uteri capsule	2	$910.70	$446.00		$89.20
58350	Reopen fallopian tube	3	$1,769.04	$510.00		$102.00
58353	Endometr ablate, thermal	4	$1,769.04	$630.00		$126.00
58545	Laparoscopic myomectomy	9	$1,965.65	$1,339.00		$267.80
58546	Laparo-myomectomy, complex	9	$2,678.23	$1,339.00		$267.80
58550	Laparo-asst vag hysterectomy	9	$4,363.07	$1,339.00		$267.80
58555	Hysteroscopy, dx, sep proc	1	$1,318.42	$333.00		$66.60
58558	Hysteroscopy, biopsy	3	$1,318.42	$510.00		$102.00
58559	Hysteroscopy, lysis	2	$1,318.42	$446.00		$89.20

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
58560	Hysteroscopy, resect septum	3	$2,049.83	$510.00		$102.00
58561	Hysteroscopy, remove myoma	3	$2,049.83	$510.00		$102.00
58562	Hysteroscopy, remove fb	3	$1,318.42	$510.00		$102.00
58563	Hysteroscopy, ablation	4	$2,049.83	$630.00		$126.00
58565	Hysteroscopy, sterilization	9	$2,639.04	$1,339.00		$267.80
58660	Laparoscopy, lysis	5	$2,678.23	$717.00		$143.40
58661	Laparoscopy, remove adnexa	5	$2,678.23	$717.00		$143.40
58662	Laparoscopy, excise lesions	5	$2,678.23	$717.00		$143.40
58670	Laparoscopy, tubal cautery	3	$2,678.23	$510.00		$102.00
58671	Laparoscopy, tubal block	3	$2,678.23	$510.00		$102.00
58672	Laparoscopy, fimbrioplasty	5	$2,678.23	$717.00		$143.40
58673	Laparoscopy, salpingostomy	5	$2,678.23	$717.00		$143.40
58800	Drainage of ovarian cyst(s)	3	$910.70	$510.00		$102.00
58820	Drain ovary abscess, open	3	$1,769.04	$510.00		$102.00
58900	Biopsy of ovary(s)	3	$910.70	$510.00		$102.00
58970	Retrieval of oocyte	1	$271.49	$271.49	Y	$54.30
58974	Transfer of embryo	1	$271.49	$271.49	Y	$54.30
58976	Transfer of embryo	1	$271.49	$271.49	Y	$54.30
59160	D& c after delivery	3	$1,093.36	$510.00		$102.00
59320	Revision of cervix	1	$1,262.49	$333.00		$66.60
59812	Treatment of miscarriage	5	$1,140.24	$717.00		$143.40
59820	Care of miscarriage	5	$1,140.24	$717.00		$143.40
59821	Treatment of miscarriage	5	$1,140.24	$717.00		$143.40
59840	Abortion	5	$1,062.41	$717.00		$143.40
59841	Abortion	5	$1,062.41	$717.00		$143.40
59870	Evacuate mole of uterus	5	$1,140.24	$717.00		$143.40
59871	Remove cerclage suture	5	$1,262.49	$717.00		$143.40
60000	Drain thyroid/tongue cyst	1	$475.55	$333.00		$66.60
60200	Remove thyroid lesion	2	$2,285.28	$446.00		$89.20
60280	Remove thyroid duct lesion	4	$2,285.28	$630.00		$126.00
60281	Remove thyroid duct lesion	4	$2,285.28	$630.00		$126.00
61020	Remove brain cavity fluid	1	$187.01	$187.01	Y	$37.40
61026	Injection into brain canal	1	$187.01	$187.01	Y	$37.40
61050	Remove brain canal fluid	1	$187.01	$187.01	Y	$37.40
61055	Injection into brain canal	1	$187.01	$187.01	Y	$37.40
61070	Brain canal shunt procedure	1	$187.01	$187.01	Y	$37.40
61215	Insert brain-fluid device	3	$2,811.11	$510.00		$102.00
61790	Treat trigeminal nerve	3	$1,093.20	$510.00		$102.00
61791	Treat trigeminal tract	3	$341.23	$341.23	Y	$68.25
61885	Insrt/redo neurostim 1 array	2	$10,828.84	$446.00		$89.20
61886	Implant neurostim arrays	3	$14,500.02	$510.00		$102.00
61888	Revise/remove neuroreceiver	1	$2,089.79	$333.00		$66.60
62194	Replace/irrigate catheter	1	$709.19	$333.00		$66.60
62225	Replace/irrigate catheter	1	$709.19	$333.00		$66.60
62230	Replace/revise brain shunt	2	$2,811.11	$446.00		$89.20
62263	Epidural lysis mult sessions	1	$765.89	$333.00		$66.60
62264	Epidural lysis on single day	1	$765.89	$333.00		$66.60
62268	Drain spinal cord cyst	1	$187.01	$187.01	Y	$37.40
62269	Needle biopsy, spinal cord	1	$373.79	$333.00		$66.60
62270	Spinal fluid tap, diagnostic	1	$138.43	$138.43	Y	$27.69
62272	Drain cerebro spinal fluid	1	$138.43	$138.43	Y	$27.69
62273	Inject epidural patch	1	$341.23	$333.00		$66.60
62280	Treat spinal cord lesion	1	$392.62	$333.00		$66.60
62281	Treat spinal cord lesion	1	$392.62	$333.00		$66.60
62282	Treat spinal canal lesion	1	$392.62	$333.00		$66.60
62287	Percutaneous diskectomy	9	$2,049.86	$1,339.00		$267.80
62294	Injection into spinal artery	3	$187.01	$187.01	Y	$37.40
62310	Inject spine c/t	1	$392.62	$333.00		$66.60
62311	Inject spine l/s (cd)	1	$392.62	$333.00		$66.60
62318	Inject spine w/cath, c/t	1	$392.62	$333.00		$66.60
62319	Inject spine w/cath l/s (cd)	1	$392.62	$333.00		$66.60
62350	Implant spinal canal cath	2	$1,803.02	$446.00		$89.20
62355	Remove spinal canal catheter	2	$765.89	$446.00		$89.20
62360	Insert spine infusion device	2	$6,894.62	$446.00		$89.20
62361	Implant spine infusion pump	2	$11,275.98	$446.00		$89.20
62362	Implant spine infusion pump	2	$11,275.98	$446.00		$89.20
62365	Remove spine infusion device	2	$2,049.86	$446.00		$89.20
63600	Remove spinal cord lesion	2	$1,093.20	$446.00		$89.20
63610	Stimulation of spinal cord	1	$1,093.20	$333.00		$66.60

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
63650	Implant neuroelectrodes	2	$3,470.58	$446.00		$89.20
63660	Revise/remove neuroelectrode	1	$1,057.63	$333.00		$66.60
63685	Insrt/redo spine n generator	2	$10,964.12	$446.00		$89.20
63688	Revise/remove neuroreceiver	1	$2,089.79	$333.00		$66.60
63744	Revision of spinal shunt	3	$2,225.70	$510.00		$102.00
63746	Removal of spinal shunt	2	$674.24	$446.00		$89.20
64410	Nblock inj, phrenic	1	$341.23	$333.00		$66.60
64415	Nblock inj, brachial plexus	1	$138.43	$138.43	Y	$27.69
64417	Nblock inj, axillary	1	$138.43	$138.43	Y	$27.69
64420	Nblock inj, intercost, sng	1	$138.43	$138.43	Y	$27.69
64421	Nblock inj, intercost, mlt	1	$341.23	$333.00		$66.60
64430	Nblock inj, pudendal	1	$138.43	$138.43	Y	$27.69
64470	Inj paravertebral c/t	1	$392.62	$333.00		$66.60
64472	Inj paravertebral c/t add-on	1	$341.23	$333.00		$66.60
64475	Inj paravertebral l/s	1	$392.62	$333.00		$66.60
64476	Inj paravertebral l/s add-on	1	$341.23	$333.00		$66.60
64479	Inj foramen epidural c/t	1	$392.62	$333.00		$66.60
64480	Inj foramen epidural add-on	1	$392.62	$333.00		$66.60
64483	Inj foramen epidural l/s	1	$392.62	$333.00		$66.60
64484	Inj foramen epidural add-on	1	$392.62	$333.00		$66.60
64510	Nblock, stellate ganglion	1	$392.62	$333.00		$66.60
64517	Nblock inj, hypogas plxs	2	$138.43	$138.43	Y	$27.69
64520	Nblock, lumbar/thoracic	1	$392.62	$333.00		$66.60
64530	Nblock inj, celiac pelus	1	$392.62	$333.00		$66.60
64553	Implant neuroelectrodes	1	$14,412.95	$333.00		$66.60
64561	Implant neuroelectrodes	3	$3,470.58	$510.00		$102.00
64573	Implant neuroelectrodes	1	$14,412.95	$333.00		$66.60
64575	Implant neuroelectrodes	1	$5,184.89	$333.00		$66.60
64577	Implant neuroelectrodes	1	$5,184.89	$333.00		$66.60
64580	Implant neuroelectrodes	1	$5,184.89	$333.00		$66.60
64581	Implant neuroelectrodes	3	$5,184.89	$510.00		$102.00
64585	Revise/remove neuroelectrode	1	$1,057.63	$333.00		$66.60
64590	Insrt/redo perph n generator	2	$10,964.12	$446.00		$89.20
64595	Revise/remove neuroreceiver	1	$2,089.79	$333.00		$66.60
64600	Injection treatment of nerve	1	$765.89	$333.00		$66.60
64605	Injection treatment of nerve	1	$765.89	$333.00		$66.60
64610	Injection treatment of nerve	1	$765.89	$333.00		$66.60
64620	Injection treatment of nerve	1	$765.89	$333.00		$66.60
64622	Destr paravertebrl nerve l/s	1	$765.89	$333.00		$66.60
64623	Destr paravertebral n add-on	1	$392.62	$333.00		$66.60
64626	Destr paravertebrl nerve c/t	1	$765.89	$333.00		$66.60
64627	Destr paravertebral n add-on	1	$392.62	$333.00		$66.60
64630	Injection treatment of nerve	2	$341.23	$341.23	Y	$68.25
64680	Injection treatment of nerve	2	$392.62	$392.62	Y	$78.52
64681	Injection treatment of nerve	2	$765.89	$446.00		$89.20
64702	Revise finger/toe nerve	1	$1,093.20	$333.00		$66.60
64704	Revise hand/foot nerve	1	$1,093.20	$333.00		$66.60
64708	Revise arm/leg nerve	2	$1,093.20	$446.00		$89.20
64712	Revision of sciatic nerve	2	$1,093.20	$446.00		$89.20
64713	Revision of arm nerve(s)	2	$1,093.20	$446.00		$89.20
64714	Revise low back nerve(s)	2	$1,093.20	$446.00		$89.20
64716	Revision of cranial nerve	3	$1,093.20	$510.00		$102.00
64718	Revise ulnar nerve at elbow	2	$1,093.20	$446.00		$89.20
64719	Revise ulnar nerve at wrist	2	$1,093.20	$446.00		$89.20
64721	Carpal tunnel surgery	2	$1,093.20	$446.00		$89.20
64722	Relieve pressure on nerve(s)	1	$1,093.20	$333.00		$66.60
64726	Release foot/toe nerve	1	$1,093.20	$333.00		$66.60
64727	Internal nerve revision	1	$1,093.20	$333.00		$66.60
64732	Incision of brow nerve	2	$1,093.20	$446.00		$89.20
64734	Incision of cheek nerve	2	$1,093.20	$446.00		$89.20
64736	Incision of chin nerve	2	$1,093.20	$446.00		$89.20
64738	Incision of jaw nerve	2	$1,093.20	$446.00		$89.20
64740	Incision of tongue nerve	2	$1,093.20	$446.00		$89.20
64742	Incision of facial nerve	2	$1,093.20	$446.00		$89.20
64744	Incise nerve, back of head	2	$1,093.20	$446.00		$89.20
64746	Incise diaphragm nerve	2	$1,093.20	$446.00		$89.20
64771	Sever cranial nerve	2	$1,093.20	$446.00		$89.20
64772	Incision of spinal nerve	2	$1,093.20	$446.00		$89.20
64774	Remove skin nerve lesion	2	$1,093.20	$446.00		$89.20

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
64776	Remove digit nerve lesion	3	$1,093.20	$510.00		$102.00
64778	Digit nerve surgery add-on	2	$1,093.20	$446.00		$89.20
64782	Remove limb nerve lesion	3	$1,093.20	$510.00		$102.00
64783	Limb nerve surgery add-on	2	$1,093.20	$446.00		$89.20
64784	Remove nerve lesion	3	$1,093.20	$510.00		$102.00
64786	Remove sciatic nerve lesion	3	$2,049.86	$510.00		$102.00
64787	Implant nerve end	2	$1,093.20	$446.00		$89.20
64788	Remove skin nerve lesion	3	$1,093.20	$510.00		$102.00
64790	Removal of nerve lesion	3	$1,093.20	$510.00		$102.00
64792	Removal of nerve lesion	3	$2,049.86	$510.00		$102.00
64795	Biopsy of nerve	2	$1,093.20	$446.00		$89.20
64802	Remove sympathetic nerves	2	$1,093.20	$446.00		$89.20
64821	Remove sympathetic nerves	4	$1,590.63	$630.00		$126.00
64831	Repair of digit nerve	4	$2,049.86	$630.00		$126.00
64832	Repair nerve add-on	1	$2,049.86	$333.00		$66.60
64834	Repair of hand or foot nerve	2	$2,049.86	$446.00		$89.20
64835	Repair of hand or foot nerve	3	$2,049.86	$510.00		$102.00
64836	Repair of hand or foot nerve	3	$2,049.86	$510.00		$102.00
64837	Repair nerve add-on	1	$2,049.86	$333.00		$66.60
64840	Repair of leg nerve	2	$2,049.86	$446.00		$89.20
64856	Repair/transpose nerve	2	$2,049.86	$446.00		$89.20
64857	Repair arm/leg nerve	2	$2,049.86	$446.00		$89.20
64858	Repair sciatic nerve	2	$2,049.86	$446.00		$89.20
64859	Nerve surgery	1	$2,049.86	$333.00		$66.60
64861	Repair of arm nerves	3	$2,049.86	$510.00		$102.00
64862	Repair of low back nerves	3	$2,049.86	$510.00		$102.00
64864	Repair of facial nerve	3	$2,049.86	$510.00		$102.00
64865	Repair of facial nerve	4	$2,049.86	$630.00		$126.00
64870	Fusion of facial/other nerve	4	$2,049.86	$630.00		$126.00
64872	Subsequent repair of nerve	2	$2,049.86	$446.00		$89.20
64874	Repair & revise nerve add-on	3	$2,049.86	$510.00		$102.00
64876	Repair nerve/shorten bone	3	$2,049.86	$510.00		$102.00
64885	Nerve graft, head or neck	2	$2,049.86	$446.00		$89.20
64886	Nerve graft, head or neck	2	$2,049.86	$446.00		$89.20
64890	Nerve graft, hand or foot	2	$2,049.86	$446.00		$89.20
64891	Nerve graft, hand or foot	2	$2,049.86	$446.00		$89.20
64892	Nerve graft, arm or leg	2	$2,049.86	$446.00		$89.20
64893	Nerve graft, arm or leg	2	$2,049.86	$446.00		$89.20
64895	Nerve graft, hand or foot	3	$2,049.86	$510.00		$102.00
64896	Nerve graft, hand or foot	3	$2,049.86	$510.00		$102.00
64897	Nerve graft, arm or leg	3	$2,049.86	$510.00		$102.00
64898	Nerve graft, arm or leg	3	$2,049.86	$510.00		$102.00
64901	Nerve graft add-on	2	$2,049.86	$446.00		$89.20
64902	Nerve graft add-on	2	$2,049.86	$446.00		$89.20
64905	Nerve pedicle transfer	2	$2,049.86	$446.00		$89.20
64907	Nerve pedicle transfer	1	$2,049.86	$333.00		$66.60
65091	Revise eye	3	$2,186.40	$510.00		$102.00
65093	Revise eye with implant	3	$2,186.40	$510.00		$102.00
65101	Removal of eye	3	$2,186.40	$510.00		$102.00
65103	Remove eye/insert implant	3	$2,186.40	$510.00		$102.00
65105	Remove eye/attach implant	4	$2,186.40	$630.00		$126.00
65110	Removal of eye	5	$2,186.40	$717.00		$143.40
65112	Remove eye/revise socket	7	$2,186.40	$995.00		$199.00
65114	Remove eye/revise socket	7	$2,186.40	$995.00		$199.00
65130	Insert ocular implant	3	$1,529.55	$510.00		$102.00
65135	Insert ocular implant	2	$1,529.55	$446.00		$89.20
65140	Attach ocular implant	3	$2,186.40	$510.00		$102.00
65150	Revise ocular implant	2	$1,529.55	$446.00		$89.20
65155	Reinsert ocular implant	3	$2,186.40	$510.00		$102.00
65175	Removal of ocular implant	1	$1,047.14	$333.00		$66.60
65235	Remove foreign body from eye	2	$923.07	$446.00		$89.20
65260	Remove foreign body from eye	3	$1,005.95	$510.00		$102.00
65265	Remove foreign body from eye	4	$1,657.60	$630.00		$126.00
65270	Repair of eye wound	2	$1,047.14	$446.00		$89.20
65272	Repair of eye wound	2	$1,412.47	$446.00		$89.20
65275	Repair of eye wound	4	$1,412.47	$630.00		$126.00
65280	Repair of eye wound	4	$1,005.95	$630.00		$126.00
65285	Repair of eye wound	4	$2,270.12	$630.00		$126.00
65290	Repair of eye socket wound	3	$1,310.33	$510.00		$102.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
65400	Removal of eye lesion	1	$923.07	$333.00		$66.60
65410	Biopsy of cornea	2	$923.07	$446.00		$89.20
65420	Removal of eye lesion	2	$923.07	$446.00		$89.20
65426	Removal of eye lesion	5	$1,412.47	$717.00		$143.40
65710	Corneal transplant	7	$2,335.53	$995.00		$199.00
65730	Corneal transplant	7	$2,335.53	$995.00		$199.00
65750	Corneal transplant	7	$2,335.53	$995.00		$199.00
65755	Corneal transplant	7	$2,335.53	$995.00		$199.00
65770	Revise cornea with implant	7	$3,116.62	$995.00		$199.00
65772	Correction of astigmatism	4	$923.07	$630.00		$126.00
65775	Correction of astigmatism	4	$923.07	$630.00		$126.00
65780	Ocular reconst, transplant	5	$2,335.53	$717.00		$143.40
65781	Ocular reconst, transplant	5	$2,335.53	$717.00		$143.40
65782	Ocular reconst, transplant	5	$2,335.53	$717.00		$143.40
65800	Drainage of eye	1	$923.07	$333.00		$66.60
65805	Drainage of eye	1	$923.07	$333.00		$66.60
65810	Drainage of eye	3	$1,412.47	$510.00		$102.00
65815	Drainage of eye	2	$1,412.47	$446.00		$89.20
65820	Relieve inner eye pressure	1	$368.07	$333.00		$66.60
65850	Incision of eye	4	$1,412.47	$630.00		$126.00
65865	Incise inner eye adhesions	1	$923.07	$333.00		$66.60
65870	Incise inner eye adhesions	4	$1,412.47	$630.00		$126.00
65875	Incise inner eye adhesions	4	$1,412.47	$630.00		$126.00
65880	Incise inner eye adhesions	4	$923.07	$630.00		$126.00
65900	Remove eye lesion	5	$923.07	$717.00		$143.40
65920	Remove implant of eye	7	$1,412.47	$995.00		$199.00
65930	Remove blood clot from eye	5	$1,412.47	$717.00		$143.40
66020	Injection treatment of eye	1	$923.07	$333.00		$66.60
66030	Injection treatment of eye	1	$368.07	$333.00		$66.60
66130	Remove eye lesion	7	$1,412.47	$995.00		$199.00
66150	Glaucoma surgery	4	$1,412.47	$630.00		$126.00
66155	Glaucoma surgery	4	$1,412.47	$630.00		$126.00
66160	Glaucoma surgery	2	$1,412.47	$446.00		$89.20
66165	Glaucoma surgery	4	$1,412.47	$630.00		$126.00
66170	Glaucoma surgery	4	$1,412.47	$630.00		$126.00
66172	Incision of eye	4	$1,412.47	$630.00		$126.00
66180	Implant eye shunt	5	$2,296.20	$717.00		$143.40
66185	Revise eye shunt	2	$2,296.20	$446.00		$89.20
66220	Repair eye lesion	3	$2,270.12	$510.00		$102.00
66225	Repair/graft eye lesion	4	$2,296.20	$630.00		$126.00
66250	Follow-up surgery of eye	2	$923.07	$446.00		$89.20
66500	Incision of iris	1	$368.07	$333.00		$66.60
66505	Incision of iris	1	$368.07	$333.00		$66.60
66600	Remove iris and lesion	3	$1,412.47	$510.00		$102.00
66605	Removal of iris	3	$1,412.47	$510.00		$102.00
66625	Removal of iris	3	$368.07	$368.07	Y	$73.61
66630	Removal of iris	3	$1,412.47	$510.00		$102.00
66635	Removal of iris	3	$1,412.47	$510.00		$102.00
66680	Repair iris & ciliary body	3	$1,412.47	$510.00		$102.00
66682	Repair iris & ciliary body	2	$1,412.47	$446.00		$89.20
66700	Destruction, ciliary body	2	$923.07	$446.00		$89.20
66710	Ciliary transsleral therapy	2	$923.07	$446.00		$89.20
66711	Ciliary endoscopic ablation	2	$923.07	$446.00		$89.20
66720	Destruction, ciliary body	2	$923.07	$446.00		$89.20
66740	Destruction, ciliary body	2	$1,412.47	$446.00		$89.20
66821	After cataract laser surgery	2	$315.55	$315.55	Y	$63.11
66825	Reposition intraocular lens	4	$1,412.47	$630.00		$126.00
66830	Removal of lens lesion	4	$368.07	$368.07	Y	$73.61
66840	Removal of lens material	4	$895.12	$630.00		$126.00
66850	Removal of lens material	7	$1,754.47	$995.00		$199.00
66852	Removal of lens material	4	$1,754.47	$630.00		$126.00
66920	Extraction of lens	4	$1,754.47	$630.00		$126.00
66930	Extraction of lens	5	$1,754.47	$717.00		$143.40
66940	Extraction of lens	5	$895.12	$717.00		$143.40
66982	Cataract surgery, complex	8	$1,450.54	$973.00		$194.60
66983	Cataract surg w/iol, 1 stage	8	$1,450.54	$973.00		$194.60
66984	Cataract surg w/iol, 1 stage	8	$1,450.54	$973.00		$194.60
66985	Insert lens prosthesis	6	$1,450.54	$826.00		$165.20
66986	Exchange lens prosthesis	6	$1,450.54	$826.00		$165.20

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
67005	Partial removal of eye fluid	4	$1,657.60	$630.00		$126.00
67010	Partial removal of eye fluid	4	$1,657.60	$630.00		$126.00
67015	Release of eye fluid	1	$1,657.60	$333.00		$66.60
67025	Replace eye fluid	1	$1,657.60	$333.00		$66.60
67027	Implant eye drug system	4	$2,270.12	$630.00		$126.00
67030	Incise inner eye strands	1	$1,005.95	$333.00		$66.60
67031	Laser surgery, eye strands	2	$315.55	$315.55	Y	$63.11
67036	Removal of inner eye fluid	4	$2,270.12	$630.00		$126.00
67038	Strip retinal membrane	5	$2,270.12	$717.00		$143.40
67039	Laser treatment of retina	7	$2,270.12	$995.00		$199.00
67040	Laser treatment of retina	7	$2,270.12	$995.00		$199.00
67107	Repair detached retina	5	$2,270.12	$717.00		$143.40
67108	Repair detached retina	7	$2,270.12	$995.00		$199.00
67112	Rerepair detached retina	7	$2,270.12	$995.00		$199.00
67115	Release encircling material	2	$1,005.95	$446.00		$89.20
67120	Remove eye implant material	2	$1,005.95	$446.00		$89.20
67121	Remove eye implant material	2	$1,657.60	$446.00		$89.20
67141	Treatment of retina	2	$250.82	$250.82	Y	$50.16
67218	Treatment of retinal lesion	5	$1,005.95	$717.00		$143.40
67227	Treatment of retinal lesion	1	$1,657.60	$333.00		$66.60
67250	Reinforce eye wall	3	$1,047.14	$510.00		$102.00
67255	Reinforce/graft eye wall	3	$1,657.60	$510.00		$102.00
67311	Revise eye muscle	3	$1,310.33	$510.00		$102.00
67312	Revise two eye muscles	4	$1,310.33	$630.00		$126.00
67314	Revise eye muscle	4	$1,310.33	$630.00		$126.00
67316	Revise two eye muscles	4	$1,310.33	$630.00		$126.00
67318	Revise eye muscle(s)	4	$1,310.33	$630.00		$126.00
67320	Revise eye muscle(s) add-on	4	$1,310.33	$630.00		$126.00
67331	Eye surgery follow-up add-on	4	$1,310.33	$630.00		$126.00
67332	Rerevise eye muscles add-on	4	$1,310.33	$630.00		$126.00
67334	Revise eye muscle w/suture	4	$1,310.33	$630.00		$126.00
67335	Eye suture during surgery	4	$1,310.33	$630.00		$126.00
67340	Revise eye muscle add-on	4	$1,310.33	$630.00		$126.00
67343	Release eye tissue	7	$1,310.33	$995.00		$199.00
67350	Biopsy eye muscle	1	$858.69	$333.00		$66.60
67400	Explore/biopsy eye socket	3	$1,529.55	$510.00		$102.00
67405	Explore/drain eye socket	4	$1,529.55	$630.00		$126.00
67412	Explore/treat eye socket	5	$1,529.55	$717.00		$143.40
67413	Explore/treat eye socket	5	$1,529.55	$717.00		$143.40
67415	Aspiration, orbital contents	1	$1,047.14	$333.00		$66.60
67420	Explore/treat eye socket	5	$2,186.40	$717.00		$143.40
67430	Explore/treat eye socket	5	$2,186.40	$717.00		$143.40
67440	Explore/drain eye socket	5	$2,186.40	$717.00		$143.40
67445	Explr/decompress eye socket	5	$2,186.40	$717.00		$143.40
67450	Explore/biopsy eye socket	5	$2,186.40	$717.00		$143.40
67550	Insert eye socket implant	4	$2,186.40	$630.00		$126.00
67560	Revise eye socket implant	2	$1,529.55	$446.00		$89.20
67570	Decompress optic nerve	4	$2,186.40	$630.00		$126.00
67715	Incision of eyelid fold	1	$1,047.14	$333.00		$66.60
67808	Remove eyelid lesion(s)	2	$1,047.14	$446.00		$89.20
67830	Revise eyelashes	2	$426.88	$426.88	Y	$85.38
67835	Revise eyelashes	2	$1,047.14	$446.00		$89.20
67880	Revision of eyelid	3	$923.07	$510.00		$102.00
67882	Revision of eyelid	3	$1,047.14	$510.00		$102.00
67900	Repair brow defect	4	$1,047.14	$630.00		$126.00
67901	Repair eyelid defect	5	$1,047.14	$717.00		$143.40
67902	Repair eyelid defect	5	$1,047.14	$717.00		$143.40
67903	Repair eyelid defect	4	$1,047.14	$630.00		$126.00
67904	Repair eyelid defect	4	$1,047.14	$630.00		$126.00
67906	Repair eyelid defect	5	$1,047.14	$717.00		$143.40
67908	Repair eyelid defect	4	$1,047.14	$630.00		$126.00
67909	Revise eyelid defect	4	$1,047.14	$630.00		$126.00
67911	Revise eyelid defect	3	$1,047.14	$510.00		$102.00
67912	Correction eyelid w/implant	3	$1,047.14	$510.00		$102.00
67914	Repair eyelid defect	3	$1,047.14	$510.00		$102.00
67916	Repair eyelid defect	4	$1,047.14	$630.00		$126.00
67917	Repair eyelid defect	4	$1,047.14	$630.00		$126.00
67921	Repair eyelid defect	3	$1,047.14	$510.00		$102.00
67923	Repair eyelid defect	4	$1,047.14	$630.00		$126.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
67924	Repair eyelid defect	4	$1,047.14	$630.00		$126.00
67935	Repair eyelid wound	2	$1,047.14	$446.00		$89.20
67950	Revision of eyelid	2	$1,047.14	$446.00		$89.20
67961	Revision of eyelid	3	$1,047.14	$510.00		$102.00
67966	Revision of eyelid	3	$1,047.14	$510.00		$102.00
67971	Reconstruction of eyelid	3	$1,529.55	$510.00		$102.00
67973	Reconstruction of eyelid	3	$1,529.55	$510.00		$102.00
67974	Reconstruction of eyelid	3	$1,529.55	$510.00		$102.00
67975	Reconstruction of eyelid	3	$1,047.14	$510.00		$102.00
68115	Remove eyelid lining lesion	2	$1,047.14	$446.00		$89.20
68130	Remove eyelid lining lesion	2	$923.07	$446.00		$89.20
68320	Revise/graft eyelid lining	4	$1,047.14	$630.00		$126.00
68325	Revise/graft eyelid lining	4	$1,529.55	$630.00		$126.00
68326	Revise/graft eyelid lining	4	$1,529.55	$630.00		$126.00
68328	Revise/graft eyelid lining	4	$1,529.55	$630.00		$126.00
68330	Revise eyelid lining	4	$1,412.47	$630.00		$126.00
68335	Revise/graft eyelid lining	4	$1,529.55	$630.00		$126.00
68340	Separate eyelid adhesions	4	$1,047.14	$630.00		$126.00
68360	Revise eyelid lining	2	$1,412.47	$446.00		$89.20
68362	Revise eyelid lining	2	$1,412.47	$446.00		$89.20
68371	Harvest eye tissue, alograft	2	$923.07	$446.00		$89.20
68500	Removal of tear gland	3	$1,529.55	$510.00		$102.00
68505	Partial removal, tear gland	3	$1,529.55	$510.00		$102.00
68510	Biopsy of tear gland	1	$1,047.14	$333.00		$66.60
68520	Removal of tear sac	3	$1,529.55	$510.00		$102.00
68525	Biopsy of tear sac	1	$1,047.14	$333.00		$66.60
68540	Remove tear gland lesion	3	$1,529.55	$510.00		$102.00
68550	Remove tear gland lesion	3	$1,529.55	$510.00		$102.00
68700	Repair tear ducts	2	$1,529.55	$446.00		$89.20
68720	Create tear sac drain	4	$1,529.55	$630.00		$126.00
68745	Create tear duct drain	4	$1,529.55	$630.00		$126.00
68750	Create tear duct drain	4	$1,529.55	$630.00		$126.00
68770	Close tear system fistula	4	$1,047.14	$630.00		$126.00
68810	Probe nasolacrimal duct	1	$135.01	$135.01	Y	$27.00
68811	Probe nasolacrimal duct	2	$1,047.14	$446.00		$89.20
68815	Probe nasolacrimal duct	2	$1,047.14	$446.00		$89.20
69110	Remove external ear, partial	1	$920.58	$333.00		$66.60
69120	Removal of external ear	2	$1,425.30	$446.00		$89.20
69140	Remove ear canal lesion(s)	2	$1,425.30	$446.00		$89.20
69145	Remove ear canal lesion(s)	2	$920.58	$446.00		$89.20
69150	Extensive ear canal surgery	3	$475.55	$475.55	Y	$95.11
69205	Clear outer ear canal	1	$1,229.54	$333.00		$66.60
69300	Revise external ear	3	$1,425.30	$510.00		$102.00
69310	Rebuild outer ear canal	3	$2,324.90	$510.00		$102.00
69320	Rebuild outer ear canal	7	$2,324.90	$995.00		$199.00
69421	Incision of eardrum	3	$1,012.48	$510.00		$102.00
69436	Create eardrum opening	3	$1,012.48	$510.00		$102.00
69440	Exploration of middle ear	3	$1,425.30	$510.00		$102.00
69450	Eardrum revision	1	$2,324.90	$333.00		$66.60
69501	Mastoidectomy	7	$2,324.90	$995.00		$199.00
69502	Mastoidectomy	7	$1,425.30	$995.00		$199.00
69505	Remove mastoid structures	7	$2,324.90	$995.00		$199.00
69511	Extensive mastoid surgery	7	$2,324.90	$995.00		$199.00
69530	Extensive mastoid surgery	7	$2,324.90	$995.00		$199.00
69550	Remove ear lesion	5	$2,324.90	$717.00		$143.40
69552	Remove ear lesion	7	$2,324.90	$995.00		$199.00
69601	Mastoid surgery revision	7	$2,324.90	$995.00		$199.00
69602	Mastoid surgery revision	7	$2,324.90	$995.00		$199.00
69603	Mastoid surgery revision	7	$2,324.90	$995.00		$199.00
69604	Mastoid surgery revision	7	$2,324.90	$995.00		$199.00
69605	Mastoid surgery revision	7	$2,324.90	$995.00		$199.00
69620	Repair of eardrum	2	$1,425.30	$446.00		$89.20
69631	Repair eardrum structures	5	$2,324.90	$717.00		$143.40
69632	Rebuild eardrum structures	5	$2,324.90	$717.00		$143.40
69633	Rebuild eardrum structures	5	$2,324.90	$717.00		$143.40
69635	Repair eardrum structures	7	$2,324.90	$995.00		$199.00
69636	Rebuild eardrum structures	7	$2,324.90	$995.00		$199.00
69637	Rebuild eardrum structures	7	$2,324.90	$995.00		$199.00
69641	Revise middle ear & mastoid	7	$2,324.90	$995.00		$199.00

ADDENDUM AA.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2007 WITH ADDITIONS AND PAYMENT RATES; INCLUDING RATES THAT RESULT FROM IMPLEMENTATION OF SECTION 5103 OF THE DRA—Continued

HCPCS	Short Descriptor	ASC Payment Group	OPPS Payment Rate	ASC Payment Rate	DRA Cap	ASC Copayment Amount
69642	Revise middle ear & mastoid	7	$2,324.90	$995.00		$199.00
69643	Revise middle ear & mastoid	7	$2,324.90	$995.00		$199.00
69644	Revise middle ear & mastoid	7	$2,324.90	$995.00		$199.00
69645	Revise middle ear & mastoid	7	$2,324.90	$995.00		$199.00
69646	Revise middle ear & mastoid	7	$2,324.90	$995.00		$199.00
69650	Release middle ear bone	7	$1,425.30	$995.00		$199.00
69660	Revise middle ear bone	5	$2,324.90	$717.00		$143.40
69661	Revise middle ear bone	5	$2,324.90	$717.00		$143.40
69662	Revise middle ear bone	5	$2,324.90	$717.00		$143.40
69666	Repair middle ear structures	4	$2,324.90	$630.00		$126.00
69667	Repair middle ear structures	4	$2,324.90	$630.00		$126.00
69670	Remove mastoid air cells	3	$2,324.90	$510.00		$102.00
69676	Remove middle ear nerve	3	$2,324.90	$510.00		$102.00
69700	Close mastoid fistula	3	$2,324.90	$510.00		$102.00
69711	Remove/repair hearing aid	1	$2,324.90	$333.00		$66.60
69714	Implant temple bone w/stimul	9	$2,324.90	$1,339.00		$267.80
69715	Temple bne implnt w/stimulat	9	$2,324.90	$1,339.00		$267.80
69717	Temple bone implant revision	9	$2,324.90	$1,339.00		$267.80
69718	Revise temple bone implant	9	$2,324.90	$1,339.00		$267.80
69720	Release facial nerve	5	$2,324.90	$717.00		$143.40
69740	Repair facial nerve	5	$2,324.90	$717.00		$143.40
69745	Repair facial nerve	5	$2,324.90	$717.00		$143.40
69801	Incise inner ear	5	$2,324.90	$717.00		$143.40
69802	Incise inner ear	7	$2,324.90	$995.00		$199.00
69805	Explore inner ear	7	$2,324.90	$995.00		$199.00
69806	Explore inner ear	7	$2,324.90	$995.00		$199.00
69820	Establish inner ear window	5	$2,324.90	$717.00		$143.40
69840	Revise inner ear window	5	$2,324.90	$717.00		$143.40
69905	Remove inner ear	7	$2,324.90	$995.00		$199.00
69910	Remove inner ear & mastoid	7	$2,324.90	$995.00		$199.00
69915	Incise inner ear nerve	7	$2,324.90	$995.00		$199.00
69930	Implant cochlear device	7	$25,040.37	$995.00		$199.00
G0105	Colorectal scrn; hi risk ind	2	$480.92	$446.00		$89.20
G0121	Colon ca scrn; not high rsk	2	$480.92	$446.00		$89.20
G0260	Inj for sacroiliac jt anesth	1	$341.23	$333.00		$66.60

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00100	Anesth, salivary gland		N					
00102	Anesth, repair of cleft lip		N					
00103	Anesth, blepharoplasty		N					
00104	Anesth, electroshock		N					
00120	Anesth, ear surgery		N					
00124	Anesth, ear exam		N					
00126	Anesth, tympanotomy		N					
00140	Anesth, procedures on eye		N					
00142	Anesth, lens surgery		N					
00144	Anesth, corneal transplant		N					
00145	Anesth, vitreoretinal surg		N					
00147	Anesth, iridectomy		N					
00148	Anesth, eye exam		N					
00160	Anesth, nose/sinus surgery		N					
00162	Anesth, nose/sinus surgery		N					
00164	Anesth, biopsy of nose		N					
00170	Anesth, procedure on mouth		N					
00172	Anesth, cleft palate repair		N					
00174	Anesth, pharyngeal surgery		N					
00190	Anesth, face/skull bone surg		N					
00210	Anesth, open head surgery		N					
00212	Anesth, skull drainage		N					
00216	Anesth, head vessel surgery		N					
00218	Anesth, special head surgery		N					
00220	Anesth, intrcrn nerve		N					
00222	Anesth, head nerve surgery		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
00410	Anesth, correct heart rhythm		N					
00450	Anesth, surgery of shoulder		N					
00454	Anesth, collar bone biopsy		N					
00470	Anesth, removal of rib		N					
00472	Anesth, chest wall repair		N					
00500	Anesth, esophageal surgery		N					
00520	Anesth, chest procedure		N					
00522	Anesth, chest lining biopsy		N					
00528	Anesth, chest partition view		N					
00529	Anesth, chest partition view		N					
00530	Anesth, pacemaker insertion		N					
00532	Anesth, vascular access		N					
00534	Anesth, cardioverter/defib		N					
00537	Anesth, cardiac electrophys		N					
00539	Anesth, trach-bronch reconst		N					
00541	Anesth, one lung ventilation		N					
00548	Anesth, trachea,bronchi surg		N					
00550	Anesth, sternal debridement		N					
00563	Anesth, heart surg w/arrest		N					
00566	Anesth, cabg w/o pump		N					
00600	Anesth, spine, cord surgery		N					
00620	Anesth, spine, cord surgery		N					
00630	Anesth, spine, cord surgery		N					
00634	Anesth for chemonucleolysis		N					
00635	Anesth, lumbar puncture		N					
00640	Anesth, spine manipulation		N					
00700	Anesth, abdominal wall surg		N					
00702	Anesth, for liver biopsy		N					
00730	Anesth, abdominal wall surg		N					
00740	Anesth, upper gi visualize		N					
00750	Anesth, repair of hernia		N					
00752	Anesth, repair of hernia		N					
00754	Anesth, repair of hernia		N					
00756	Anesth, repair of hernia		N					
00770	Anesth, blood vessel repair		N					
00790	Anesth, surg upper abdomen		N					
00797	Anesth, surgery for obesity		N					
00800	Anesth, abdominal wall surg		N					
00810	Anesth, low intestine scope		N					
00820	Anesth, abdominal wall surg		N					
00830	Anesth, repair of hernia		N					
00832	Anesth, repair of hernia		N					
00834	Anesth, hernia repair < 1 yr		N					
00836	Anesth hernia repair preemie		N					
00840	Anesth, surg lower abdomen		N					
00842	Anesth, amniocentesis		N					
00851	Anesth, tubal ligation		N					
00860	Anesth, surgery of abdomen		N					
00862	Anesth, kidney/ureter surg		N					
00870	Anesth, bladder stone surg		N					
00872	Anesth kidney stone destruct		N					
00873	Anesth kidney stone destruct		N					
00880	Anesth, abdomen vessel surg		N					
00902	Anesth, anorectal surgery		N					
00906	Anesth, removal of vulva		N					
00910	Anesth, bladder surgery		N					
00912	Anesth, bladder tumor surg		N					
00914	Anesth, removal of prostate		N					
00916	Anesth, bleeding control		N					
00918	Anesth, stone removal		N					
00920	Anesth, genitalia surgery		N					
00921	Anesth, vasectomy		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00922	Anesth, sperm duct surgery		N					
00924	Anesth, testis exploration		N					
00926	Anesth, removal of testis		N					
00928	Anesth, removal of testis		N					
00930	Anesth, testis suspension		N					
00938	Anesth, insert penis device		N					
00940	Anesth, vaginal procedures		N					
00942	Anesth, surg on vag/urethral		N					
00948	Anesth, repair of cervix		N					
00950	Anesth, vaginal endoscopy		N					
00952	Anesth, hysteroscope/graph		N					
01112	Anesth, bone aspirate/bx		N					
01120	Anesth, pelvis surgery		N					
01130	Anesth, body cast procedure		N					
01160	Anesth, pelvis procedure		N					
01170	Anesth, pelvis surgery		N					
01173	Anesth, fx repair, pelvis		N					
01180	Anesth, pelvis nerve removal		N					
01190	Anesth, pelvis nerve removal		N					
01200	Anesth, hip joint procedure		N					
01202	Anesth, arthroscopy of hip		N					
01210	Anesth, hip joint surgery		N					
01215	Anesth, revise hip repair		N					
01220	Anesth, procedure on femur		N					
01230	Anesth, surgery of femur		N					
01250	Anesth, upper leg surgery		N					
01260	Anesth, upper leg veins surg		N					
01270	Anesth, thigh arteries surg		N					
01320	Anesth, knee area surgery		N					
01340	Anesth, knee area procedure		N					
01360	Anesth, knee area surgery		N					
01380	Anesth, knee joint procedure		N					
01382	Anesth, dx knee arthroscopy		N					
01390	Anesth, knee area procedure		N					
01392	Anesth, knee area surgery		N					
01400	Anesth, knee joint surgery		N					
01420	Anesth, knee joint casting		N					
01430	Anesth, knee veins surgery		N					
01432	Anesth, knee vessel surg		N					
01440	Anesth, knee arteries surg		N					
01462	Anesth, lower leg procedure		N					
01464	Anesth, ankle/ft arthroscopy		N					
01470	Anesth, lower leg surgery		N					
01472	Anesth, achilles tendon surg		N					
01474	Anesth, lower leg surgery		N					
01480	Anesth, lower leg bone surg		N					
01482	Anesth, radical leg surgery		N					
01484	Anesth, lower leg revision		N					
01490	Anesth, lower leg casting		N					
01500	Anesth, leg arteries surg		N					
01520	Anesth, lower leg vein surg		N					
01522	Anesth, lower leg vein surg		N					
01610	Anesth, surgery of shoulder		N					
01620	Anesth, shoulder procedure		N					
01622	Anes dx shoulder arthroscopy		N					
01630	Anesth, surgery of shoulder		N					
01650	Anesth, shoulder artery surg		N					
01670	Anesth, shoulder vein surg		N					
01680	Anesth, shoulder casting		N					
01682	Anesth, airplane cast		N					
01710	Anesth, elbow area surgery		N					
01712	Anesth, uppr arm tendon surg		N					
01714	Anesth, uppr arm tendon surg		N					
01716	Anesth, biceps tendon repair		N					
01730	Anesth, uppr arm procedure		N					
01732	Anesth, dx elbow arthroscopy		N					
01740	Anesth, upper arm surgery		N					
01742	Anesth, humerus surgery		N					
01744	Anesth, humerus repair		N					
01758	Anesth, humeral lesion surg		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01760	Anesth, elbow replacement		N					
01770	Anesth, uppr arm artery surg		N					
01772	Anesth, uppr arm embolectomy		N					
01780	Anesth, upper arm vein surg		N					
01782	Anesth, uppr arm vein repair		N					
01810	Anesth, lower arm surgery		N					
01820	Anesth, lower arm procedure		N					
01829	Anesth, dx wrist arthroscopy		N					
01830	Anesth, lower arm surgery		N					
01832	Anesth, wrist replacement		N					
01840	Anesth, lwr arm artery surg		N					
01842	Anesth, lwr arm embolectomy		N					
01844	Anesth, vascular shunt surg		N					
01850	Anesth, lower arm vein surg		N					
01852	Anesth, lwr arm vein repair		N					
01860	Anesth, lower arm casting		N					
01905	Anes, spine inject, x-ray/re		N					
01916	Anesth, dx arteriography		N					
01920	Anesth, catheterize heart		N					
01922	Anesth, cat or MRI scan		N					
01924	Anes, ther interven rad, art		N					
01925	Anes, ther interven rad, car		N					
01926	Anes, tx interv rad hrt/cran		N					
01930	Anes, ther interven rad, vei		N					
01931	Anes, ther interven rad, tip		N					
01932	Anes, tx interv rad, th vein		N					
01933	Anes, tx interv rad, cran v		N					
01951	Anesth, burn, less 4 percent		N					
01952	Anesth, burn, 4–9 percent		N					
01953	Anesth, burn, each 9 percent		N					
01958	Anesth, antepartum manipul		N					
01960	Anesth, vaginal delivery		N					
01961	Anesth, cs delivery		N					
01962	Anesth, emer hysterectomy		N					
01963	Anesth, cs hysterectomy		N					
01965	Anesth, inc/missed ab proc		N					
01966	Anesth, induced ab procedure		N					
01967	Anesth/analg, vag delivery		N					
01968	Anes/analg cs deliver add-on		N					
01969	Anesth/analg cs hyst add-on		N					
01991	Anesth, nerve block/inj		N					
01992	Anesth, n block/inj, prone		N					
01995	Regional anesthesia limb		N					
01996	Hosp manage cont drug admin		N					
01999	Unlisted anesth procedure		N					
10021	Fna w/o image		T	0002	1.0948	67.39		13.48
10022	Fna w/image		T	0036	2.0147	124.01		24.80
10040	Acne surgery		T	0010	0.4829	29.72	8.14	5.94
10060	Drainage of skin abscess		T	0006	1.4821	91.22	21.76	18.24
10061	Drainage of skin abscess		T	0006	1.4821	91.22	21.76	18.24
10080	Drainage of pilonidal cyst		T	0006	1.4821	91.22	21.76	18.24
10081	Drainage of pilonidal cyst		T	0007	10.9184	672.04		134.41
10120	Remove foreign body		T	0006	1.4821	91.22	21.76	18.24
10121	Remove foreign body		T	0021	14.9563	920.58	219.48	184.12
10140	Drainage of hematoma/fluid		T	0007	10.9184	672.04		134.41
10160	Puncture drainage of lesion		T	0018	1.0534	64.84	15.87	12.97
10180	Complex drainage, wound		T	0008	17.4686	1,075.21		215.04
11000	Debride infected skin		T	0013	1.0876	66.94		13.39
11001	Debride infected skin add-on		T	0012	0.8076	49.71	10.30	9.94
11010	Debride skin, fx		T	0019	4.0123	246.96	71.87	49.39
11011	Debride skin/muscle, fx		T	0019	4.0123	246.96	71.87	49.39
11012	Debride skin/muscle/bone, fx		T	0019	4.0123	246.96	71.87	49.39
11040	Debride skin, partial		T	0015	1.6062	98.86	20.13	19.77
11041	Debride skin, full		T	0015	1.6062	98.86	20.13	19.77
11042	Debride skin/tissue		T	0016	2.6253	161.59	32.68	32.32
11043	Debride tissue/muscle		T	0016	2.6253	161.59	32.68	32.32
11044	Debride tissue/muscle/bone		T	0682	6.7529	415.65	158.65	83.13
11055	Trim skin lesion		T	0012	0.8076	49.71	10.30	9.94
11056	Trim skin lesions, 2 to 4		T	0012	0.8076	49.71	10.30	9.94
11057	Trim skin lesions, over 4		T	0013	1.0876	66.94		13.39

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11100	Biopsy, skin lesion		T	0018	1.0534	64.84	15.87	12.97
11101	Biopsy, skin add-on		T	0018	1.0534	64.84	15.87	12.97
11200	Removal of skin tags		T	0013	1.0876	66.94		13.39
11201	Remove skin tags add-on		T	0015	1.6062	98.86	20.13	19.77
11300	Shave skin lesion		T	0012	0.8076	49.71	10.30	9.94
11301	Shave skin lesion		T	0012	0.8076	49.71	10.30	9.94
11302	Shave skin lesion		T	0013	1.0876	66.94		13.39
11303	Shave skin lesion		T	0015	1.6062	98.86	20.13	19.77
11305	Shave skin lesion		T	0013	1.0876	66.94		13.39
11306	Shave skin lesion		T	0013	1.0876	66.94		13.39
11307	Shave skin lesion		T	0013	1.0876	66.94		13.39
11308	Shave skin lesion		T	0013	1.0876	66.94		13.39
11310	Shave skin lesion		T	0013	1.0876	66.94		13.39
11311	Shave skin lesion		T	0013	1.0876	66.94		13.39
11312	Shave skin lesion		T	0013	1.0876	66.94		13.39
11313	Shave skin lesion		T	0016	2.6253	161.59	32.68	32.32
11400	Exc tr-ext b9+marg 0.5 < cm		T	0019	4.0123	246.96	71.87	49.39
11401	Exc tr-ext b9+marg 0.6–1 cm		T	0019	4.0123	246.96	71.87	49.39
11402	Exc tr-ext b9+marg 1.1–2 cm		T	0019	4.0123	246.96	71.87	49.39
11403	Exc tr-ext b9+marg 2.1–3 cm		T	0020	6.5128	400.87	98.57	80.17
11404	Exc tr-ext b9+marg 3.1–4 cm		T	0021	14.9563	920.58	219.48	184.12
11406	Exc tr-ext b9+marg > 4.0 cm		T	0021	14.9563	920.58	219.48	184.12
11420	Exc h-f-nk-sp b9+marg 0.5 <		T	0020	6.5128	400.87	98.57	80.17
11421	Exc h-f-nk-sp b9+marg 0.6–1		T	0020	6.5128	400.87	98.57	80.17
11422	Exc h-f-nk-sp b9+marg 1.1–2		T	0020	6.5128	400.87	98.57	80.17
11423	Exc h-f-nk-sp b9+marg 2.1–3		T	0021	14.9563	920.58	219.48	184.12
11424	Exc h-f-nk-sp b9+marg 3.1–4		T	0021	14.9563	920.58	219.48	184.12
11426	Exc h-f-nk-sp b9+marg > 4 cm		T	0022	19.9760	1,229.54	354.45	245.91
11440	Exc face-mm b9+marg 0.5 < cm		T	0019	4.0123	246.96	71.87	49.39
11441	Exc face-mm b9+marg 0.6–1 cm		T	0019	4.0123	246.96	71.87	49.39
11442	Exc face-mm b9+marg 1.1–2 cm		T	0020	6.5128	400.87	98.57	80.17
11443	Exc face-mm b9+marg 2.1–3 cm		T	0020	6.5128	400.87	98.57	80.17
11444	Exc face-mm b9+marg 3.1–4 cm		T	0020	6.5128	400.87	98.57	80.17
11446	Exc face-mm b9+marg > 4 cm		T	0022	19.9760	1,229.54	354.45	245.91
11450	Removal, sweat gland lesion		T	0022	19.9760	1,229.54	354.45	245.91
11451	Removal, sweat gland lesion		T	0022	19.9760	1,229.54	354.45	245.91
11462	Removal, sweat gland lesion		T	0022	19.9760	1,229.54	354.45	245.91
11463	Removal, sweat gland lesion		T	0022	19.9760	1,229.54	354.45	245.91
11470	Removal, sweat gland lesion		T	0022	19.9760	1,229.54	354.45	245.91
11471	Removal, sweat gland lesion		T	0022	19.9760	1,229.54	354.45	245.91
11600	Exc tr-ext mlg+marg 0.5 < cm		T	0019	4.0123	246.96	71.87	49.39
11601	Exc tr-ext mlg+marg 0.6–1 cm		T	0019	4.0123	246.96	71.87	49.39
11602	Exc tr-ext mlg+marg 1.1–2 cm		T	0019	4.0123	246.96	71.87	49.39
11603	Exc tr-ext mlg+marg 2.1–3 cm		T	0020	6.5128	400.87	98.57	80.17
11604	Exc tr-ext mlg+marg 3.1–4 cm		T	0020	6.5128	400.87	98.57	80.17
11606	Exc tr-ext mlg+marg > 4 cm		T	0021	14.9563	920.58	219.48	184.12
11620	Exc h-f-nk-sp mlg+marg 0.5 <		T	0020	6.5128	400.87	98.57	80.17
11621	Exc h-f-nk-sp mlg+marg 0.6–1		T	0019	4.0123	246.96	71.87	49.39
11622	Exc h-f-nk-sp mlg+marg 1.1–2		T	0020	6.5128	400.87	98.57	80.17
11623	Exc h-f-nk-sp mlg+marg 2.1–3		T	0021	14.9563	920.58	219.48	184.12
11624	Exc h-f-nk-sp mlg+marg 3.1–4		T	0021	14.9563	920.58	219.48	184.12
11626	Exc h-f-nk-sp mlg+mar > 4 cm		T	0022	19.9760	1,229.54	354.45	245.91
11640	Exc face-mm malig+marg 0.5 <		T	0020	6.5128	400.87	98.57	80.17
11641	Exc face-mm malig+marg 0.6–1		T	0020	6.5128	400.87	98.57	80.17
11642	Exc face-mm malig+marg 1.1–2		T	0020	6.5128	400.87	98.57	80.17
11643	Exc face-mm malig+marg 2.1–3		T	0020	6.5128	400.87	98.57	80.17
11644	Exc face-mm malig+marg 3.1–4		T	0021	14.9563	920.58	219.48	184.12
11646	Exc face-mm mlg+marg > 4 cm		T	0022	19.9760	1,229.54	354.45	245.91
11719	Trim nail(s)		T	0009	0.6803	41.87		8.37
11720	Debride nail, 1–5		T	0009	0.6803	41.87		8.37
11721	Debride nail, 6 or more		T	0009	0.6803	41.87		8.37
11730	Removal of nail plate		T	0013	1.0876	66.94		13.39
11732	Remove nail plate, add-on		T	0012	0.8076	49.71	10.30	9.94
11740	Drain blood from under nail		T	0009	0.6803	41.87		8.37
11750	Removal of nail bed		T	0019	4.0123	246.96	71.87	49.39
11752	Remove nail bed/finger tip		T	0022	19.9760	1,229.54	354.45	245.91
11755	Biopsy, nail unit		T	0019	4.0123	246.96	71.87	49.39
11760	Repair of nail bed		T	0024	1.4924	91.86	30.08	18.37
11762	Reconstruction of nail bed		T	0024	1.4924	91.86	30.08	18.37
11765	Excision of nail fold, toe		T	0015	1.6062	98.86	20.13	19.77

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11770	Removal of pilonidal lesion		T	0022	19.9760	1,229.54	354.45	245.91
11771	Removal of pilonidal lesion		T	0022	19.9760	1,229.54	354.45	245.91
11772	Removal of pilonidal lesion		T	0022	19.9760	1,229.54	354.45	245.91
11900	Injection into skin lesions		T	0012	0.8076	49.71	10.30	9.94
11901	Added skin lesions injection		T	0012	0.8076	49.71	10.30	9.94
11920	Correct skin color defects		T	0024	1.4924	91.86	30.08	18.37
11921	Correct skin color defects		T	0024	1.4924	91.86	30.08	18.37
11922	Correct skin color defects		T	0024	1.4924	91.86	30.08	18.37
11950	Therapy for contour defects		T	0024	1.4924	91.86	30.08	18.37
11951	Therapy for contour defects		T	0024	1.4924	91.86	30.08	18.37
11952	Therapy for contour defects		T	0024	1.4924	91.86	30.08	18.37
11954	Therapy for contour defects		T	0024	1.4924	91.86	30.08	18.37
11960	Insert tissue expander(s)		T	0027	21.2645	1,308.85	329.72	261.77
11970	Replace tissue expander	CH	T	0051	41.2543	2,539.24		507.85
11971	Remove tissue expander(s)		T	0022	19.9760	1,229.54	354.45	245.91
11976	Removal of contraceptive cap		T	0019	4.0123	246.96	71.87	49.39
11980	Implant hormone pellet(s)		X	0340	0.6211	38.23		7.65
11981	Insert drug implant device		X	0340	0.6211	38.23		7.65
11982	Remove drug implant device		X	0340	0.6211	38.23		7.65
11983	Remove/insert drug implant		X	0340	0.6211	38.23		7.65
12001	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12002	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12004	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12005	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12006	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12007	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12011	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12013	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12014	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12015	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12016	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12017	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12018	Repair superficial wound(s)		T	0024	1.4924	91.86	30.08	18.37
12020	Closure of split wound		T	0024	1.4924	91.86	30.08	18.37
12021	Closure of split wound		T	0024	1.4924	91.86	30.08	18.37
12031	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12032	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12034	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12035	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12036	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12037	Layer closure of wound(s)		T	0025	5.0931	313.49	95.46	62.70
12041	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12042	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12044	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12045	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12046	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12047	Layer closure of wound(s)		T	0025	5.0931	313.49	95.46	62.70
12051	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12052	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12053	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12054	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12055	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12056	Layer closure of wound(s)		T	0024	1.4924	91.86	30.08	18.37
12057	Layer closure of wound(s)		T	0025	5.0931	313.49	95.46	62.70
13100	Repair of wound or lesion		T	0025	5.0931	313.49	95.46	62.70
13101	Repair of wound or lesion		T	0025	5.0931	313.49	95.46	62.70
13102	Repair wound/lesion add-on		T	0024	1.4924	91.86	30.08	18.37
13120	Repair of wound or lesion		T	0024	1.4924	91.86	30.08	18.37
13121	Repair of wound or lesion		T	0024	1.4924	91.86	30.08	18.37
13122	Repair wound/lesion add-on		T	0024	1.4924	91.86	30.08	18.37
13131	Repair of wound or lesion		T	0024	1.4924	91.86	30.08	18.37
13132	Repair of wound or lesion		T	0024	1.4924	91.86	30.08	18.37
13133	Repair wound/lesion add-on		T	0024	1.4924	91.86	30.08	18.37
13150	Repair of wound or lesion		T	0025	5.0931	313.49	95.46	62.70
13151	Repair of wound or lesion		T	0024	1.4924	91.86	30.08	18.37
13152	Repair of wound or lesion		T	0025	5.0931	313.49	95.46	62.70
13153	Repair wound/lesion add-on		T	0024	1.4924	91.86	30.08	18.37
13160	Late closure of wound		T	0027	21.2645	1,308.85	329.72	261.77
14000	Skin tissue rearrangement		T	0686	13.3433	821.29		164.26
14001	Skin tissue rearrangement		T	0027	21.2645	1,308.85	329.72	261.77

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
14020	Skin tissue rearrangement		T	0686	13.3433	821.29		164.26
14021	Skin tissue rearrangement	CH	T	0686	13.3433	821.29		164.26
14040	Skin tissue rearrangement		T	0686	13.3433	821.29		164.26
14041	Skin tissue rearrangement	CH	T	0686	13.3433	821.29		164.26
14060	Skin tissue rearrangement	CH	T	0686	13.3433	821.29		164.26
14061	Skin tissue rearrangement		T	0686	13.3433	821.29		164.26
14300	Skin tissue rearrangement		T	0027	21.2645	1,308.85	329.72	261.77
14350	Skin tissue rearrangement		T	0027	21.2645	1,308.85	329.72	261.77
15000	Wound prep, 1st 100 sq cm		T	0025	5.0931	313.49	95.46	62.70
15001	Wound prep, addl 100 sq cm		T	0025	5.0931	313.49	95.46	62.70
15040	Harvest cultured skin graft		T	0024	1.4924	91.86	30.08	18.37
15050	Skin pinch graft		T	0025	5.0931	313.49	95.46	62.70
15100	Skin splt grft, trnk/arm/leg		T	0027	21.2645	1,308.85	329.72	261.77
15101	Skin splt grft t/a/l, add-on		T	0027	21.2645	1,308.85	329.72	261.77
15110	Epidrm autogrft trnk/arm/leg		T	0027	21.2645	1,308.85	329.72	261.77
15111	Epidrm autogrft t/a/l add-on		T	0027	21.2645	1,308.85	329.72	261.77
15115	Epidrm a-grft face/nck/hf/g		T	0027	21.2645	1,308.85	329.72	261.77
15116	Epidrm a-grft f/n/hf/g addl		T	0027	21.2645	1,308.85	329.72	261.77
15120	Skn splt a-grft fac/nck/hf/g		T	0027	21.2645	1,308.85	329.72	261.77
15121	Skn splt a-grft f/n/hf/g add		T	0027	21.2645	1,308.85	329.72	261.77
15130	Derm autograft, trnk/arm/leg		T	0027	21.2645	1,308.85	329.72	261.77
15131	Derm autograft t/a/l add-on		T	0027	21.2645	1,308.85	329.72	261.77
15135	Derm autograft face/nck/hf/g		T	0027	21.2645	1,308.85	329.72	261.77
15136	Derm autograft, f/n/hf/g add		T	0027	21.2645	1,308.85	329.72	261.77
15150	Cult epiderm grft t/arm/leg		T	0027	21.2645	1,308.85	329.72	261.77
15151	Cult epiderm grft t/a/l addl		T	0027	21.2645	1,308.85	329.72	261.77
15152	Cult epiderm graft t/a/l +%		T	0027	21.2645	1,308.85	329.72	261.77
15155	Cult epiderm graft, f/n/hf/g		T	0027	21.2645	1,308.85	329.72	261.77
15156	Cult epidrm grft f/n/hfg add		T	0027	21.2645	1,308.85	329.72	261.77
15157	Cult epiderm grft f/n/hfg +%		T	0027	21.2645	1,308.85	329.72	261.77
15170	Acell graft trunk/arms/legs	CH	T	0025	5.0931	313.49	95.46	62.70
15171	Acell graft t/arm/leg add-on	CH	T	0025	5.0931	313.49	95.46	62.70
15175	Acellular graft, f/n/hf/g	CH	T	0025	5.0931	313.49	95.46	62.70
15176	Acell graft, f/n/hf/g add-on	CH	T	0025	5.0931	313.49	95.46	62.70
15200	Skin full graft, trunk	CH	T	0686	13.3433	821.29		164.26
15201	Skin full graft trunk add-on		T	0025	5.0931	313.49	95.46	62.70
15220	Skin full graft sclp/arm/leg	CH	T	0686	13.3433	821.29		164.26
15221	Skin full graft add-on		T	0025	5.0931	313.49	95.46	62.70
15240	Skin full grft face/genit/hf		T	0686	13.3433	821.29		164.26
15241	Skin full graft add-on		T	0025	5.0931	313.49	95.46	62.70
15260	Skin full graft een&lips		T	0686	13.3433	821.29		164.26
15261	Skin full graft add-on		T	0025	5.0931	313.49	95.46	62.70
15300	Apply skinallogrft, t/arm/lg	CH	T	0025	5.0931	313.49	95.46	62.70
15301	Apply sknallogrft t/a/l addl		T	0025	5.0931	313.49	95.46	62.70
15320	Apply skin allogrft f/n/hf/g		T	0025	5.0931	313.49	95.46	62.70
15321	Aply sknallogrft f/n/hfg add		T	0025	5.0931	313.49	95.46	62.70
15330	Aply acell alogrft t/arm/leg		T	0025	5.0931	313.49	95.46	62.70
15331	Aply acell grft t/a/l add-on		T	0025	5.0931	313.49	95.46	62.70
15335	Apply acell graft, f/n/hf/g		T	0025	5.0931	313.49	95.46	62.70
15336	Aply acell grft f/n/hf/g add		T	0025	5.0931	313.49	95.46	62.70
15340	Apply cult skin substitute	CH	T	0025	5.0931	313.49	95.46	62.70
15341	Apply cult skin sub add-on	CH	T	0025	5.0931	313.49	95.46	62.70
15360	Apply cult derm sub, t/a/l	CH	T	0025	5.0931	313.49	95.46	62.70
15361	Aply cult derm sub t/a/l add	CH	T	0025	5.0931	313.49	95.46	62.70
15365	Apply cult derm sub f/n/hf/g	CH	T	0025	5.0931	313.49	95.46	62.70
15366	Apply cult derm f/hf/g add	CH	T	0025	5.0931	313.49	95.46	62.70
15400	Apply skin xenograft, t/a/l		T	0025	5.0931	313.49	95.46	62.70
15401	Apply skn xenogrft t/a/l add		T	0025	5.0931	313.49	95.46	62.70
15420	Apply skin xgraft, f/n/hf/g		T	0025	5.0931	313.49	95.46	62.70
15421	Apply skn xgrft f/n/hf/g add		T	0025	5.0931	313.49	95.46	62.70
15430	Apply acellular xenograft		T	0025	5.0931	313.49	95.46	62.70
15431	Apply acellular xgraft add		T	0025	5.0931	313.49	95.46	62.70
15570	Form skin pedicle flap		T	0027	21.2645	1,308.85	329.72	261.77
15572	Form skin pedicle flap		T	0027	21.2645	1,308.85	329.72	261.77
15574	Form skin pedicle flap		T	0027	21.2645	1,308.85	329.72	261.77
15576	Form skin pedicle flap		T	0686	13.3433	821.29		164.26
15600	Skin graft		T	0027	21.2645	1,308.85	329.72	261.77
15610	Skin graft		T	0027	21.2645	1,308.85	329.72	261.77
15620	Skin graft		T	0027	21.2645	1,308.85	329.72	261.77
15630	Skin graft		T	0027	21.2645	1,308.85	329.72	261.77

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15650	Transfer skin pedicle flap		T	0027	21.2645	1,308.85	329.72	261.77
15732	Muscle-skin graft, head/neck		T	0027	21.2645	1,308.85	329.72	261.77
15734	Muscle-skin graft, trunk		T	0027	21.2645	1,308.85	329.72	261.77
15736	Muscle-skin graft, arm		T	0027	21.2645	1,308.85	329.72	261.77
15738	Muscle-skin graft, leg		T	0027	21.2645	1,308.85	329.72	261.77
15740	Island pedicle flap graft		T	0686	13.3433	821.29		164.26
15750	Neurovascular pedicle graft		T	0027	21.2645	1,308.85	329.72	261.77
15760	Composite skin graft		T	0027	21.2645	1,308.85	329.72	261.77
15770	Derma-fat-fascia graft		T	0027	21.2645	1,308.85	329.72	261.77
15775	Hair transplant punch grafts		T	0025	5.0931	313.49	95.46	62.70
15776	Hair transplant punch grafts		T	0025	5.0931	313.49	95.46	62.70
15780	Abrasion treatment of skin		T	0022	19.9760	1,229.54	354.45	245.91
15781	Abrasion treatment of skin		T	0019	4.0123	246.96	71.87	49.39
15782	Abrasion treatment of skin		T	0019	4.0123	246.96	71.87	49.39
15783	Abrasion treatment of skin		T	0016	2.6253	161.59	32.68	32.32
15786	Abrasion, lesion, single		T	0013	1.0876	66.94		13.39
15787	Abrasion, lesions, add-on		T	0013	1.0876	66.94		13.39
15788	Chemical peel, face, epiderm		T	0012	0.8076	49.71	10.30	9.94
15789	Chemical peel, face, dermal		T	0015	1.6062	98.86	20.13	19.77
15792	Chemical peel, nonfacial		T	0013	1.0876	66.94		13.39
15793	Chemical peel, nonfacial		T	0012	0.8076	49.71	10.30	9.94
15819	Plastic surgery, neck		T	0025	5.0931	313.49	95.46	62.70
15820	Revision of lower eyelid		T	0027	21.2645	1,308.85	329.72	261.77
15821	Revision of lower eyelid		T	0027	21.2645	1,308.85	329.72	261.77
15822	Revision of upper eyelid		T	0027	21.2645	1,308.85	329.72	261.77
15823	Revision of upper eyelid	CH	T	0686	13.3433	821.29		164.26
15824	Removal of forehead wrinkles		T	0027	21.2645	1,308.85	329.72	261.77
15825	Removal of neck wrinkles		T	0027	21.2645	1,308.85	329.72	261.77
15826	Removal of brow wrinkles		T	0027	21.2645	1,308.85	329.72	261.77
15828	Removal of face wrinkles		T	0027	21.2645	1,308.85	329.72	261.77
15829	Removal of skin wrinkles		T	0027	21.2645	1,308.85	329.72	261.77
15831	Excise excessive skin tissue		T	0022	19.9760	1,229.54	354.45	245.91
15832	Excise excessive skin tissue		T	0022	19.9760	1,229.54	354.45	245.91
15833	Excise excessive skin tissue		T	0022	19.9760	1,229.54	354.45	245.91
15834	Excise excessive skin tissue		T	0022	19.9760	1,229.54	354.45	245.91
15835	Excise excessive skin tissue		T	0025	5.0931	313.49	95.46	62.70
15836	Excise excessive skin tissue		T	0021	14.9563	920.58	219.48	184.12
15837	Excise excessive skin tissue		T	0021	14.9563	920.58	219.48	184.12
15838	Excise excessive skin tissue		T	0021	14.9563	920.58	219.48	184.12
15839	Excise excessive skin tissue		T	0021	14.9563	920.58	219.48	184.12
15840	Graft for face nerve palsy		T	0027	21.2645	1,308.85	329.72	261.77
15841	Graft for face nerve palsy		T	0027	21.2645	1,308.85	329.72	261.77
15842	Flap for face nerve palsy		T	0686	13.3433	821.29		164.26
15845	Skin and muscle repair, face		T	0027	21.2645	1,308.85	329.72	261.77
15850	Removal of sutures		T	0016	2.6253	161.59	32.68	32.32
15851	Removal of sutures		T	0016	2.6253	161.59	32.68	32.32
15852	Dressing change not for burn		X	0340	0.6211	38.23		7.65
15860	Test for blood flow in graft	CH	X	0340	0.6211	38.23		7.65
15876	Suction assisted lipectomy		T	0027	21.2645	1,308.85	329.72	261.77
15877	Suction assisted lipectomy		T	0027	21.2645	1,308.85	329.72	261.77
15878	Suction assisted lipectomy		T	0686	13.3433	821.29		164.26
15879	Suction assisted lipectomy		T	0027	21.2645	1,308.85	329.72	261.77
15920	Removal of tail bone ulcer		T	0019	4.0123	246.96	71.87	49.39
15922	Removal of tail bone ulcer		T	0027	21.2645	1,308.85	329.72	261.77
15931	Remove sacrum pressure sore		T	0022	19.9760	1,229.54	354.45	245.91
15933	Remove sacrum pressure sore		T	0022	19.9760	1,229.54	354.45	245.91
15934	Remove sacrum pressure sore		T	0027	21.2645	1,308.85	329.72	261.77
15935	Remove sacrum pressure sore		T	0027	21.2645	1,308.85	329.72	261.77
15936	Remove sacrum pressure sore		T	0027	21.2645	1,308.85	329.72	261.77
15937	Remove sacrum pressure sore		T	0027	21.2645	1,308.85	329.72	261.77
15940	Remove hip pressure sore		T	0022	19.9760	1,229.54	354.45	245.91
15941	Remove hip pressure sore		T	0022	19.9760	1,229.54	354.45	245.91
15944	Remove hip pressure sore		T	0027	21.2645	1,308.85	329.72	261.77
15945	Remove hip pressure sore		T	0027	21.2645	1,308.85	329.72	261.77
15946	Remove hip pressure sore		T	0027	21.2645	1,308.85	329.72	261.77
15950	Remove thigh pressure sore		T	0022	19.9760	1,229.54	354.45	245.91
15951	Remove thigh pressure sore		T	0022	19.9760	1,229.54	354.45	245.91
15952	Remove thigh pressure sore		T	0027	21.2645	1,308.85	329.72	261.77
15953	Remove thigh pressure sore		T	0027	21.2645	1,308.85	329.72	261.77
15956	Remove thigh pressure sore		T	0027	21.2645	1,308.85	329.72	261.77

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15958	Remove thigh pressure sore		T	0027	21.2645	1,308.85	329.72	261.77
15999	Removal of pressure sore		T	0019	4.0123	246.96	71.87	49.39
16000	Initial treatment of burn(s)		T	0012	0.8076	49.71	10.30	9.94
16020	Dress/debrid p-thick burn, s		T	0013	1.0876	66.94		13.39
16025	Dress/debrid p-thick burn, m		T	0013	1.0876	66.94		13.39
16030	Dress/debrid p-thick burn, l		T	0015	1.6062	98.86	20.13	19.77
16035	Incision of burn scab, initi	CH	T	0016	2.6253	161.59	32.68	32.32
17000	Destroy benign/premlg lesion		T	0010	0.4829	29.72	8.14	5.94
17003	Destroy lesions, 2–14		T	0010	0.4829	29.72	8.14	5.94
17004	Destroy lesions, 15 or more		T	0011	2.6478	162.97		32.59
17106	Destruction of skin lesions		T	0011	2.6478	162.97		32.59
17107	Destruction of skin lesions		T	0011	2.6478	162.97		32.59
17108	Destruction of skin lesions		T	0011	2.6478	162.97		32.59
17110	Destruct lesion, 1–14	CH	T	0012	0.8076	49.71	10.30	9.94
17111	Destruct lesion, 15 or more		T	0013	1.0876	66.94		13.39
17250	Chemical cautery, tissue		T	0013	1.0876	66.94		13.39
17260	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17261	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17262	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17263	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17264	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17266	Destruction of skin lesions		T	0016	2.6253	161.59	32.68	32.32
17270	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17271	Destruction of skin lesions		T	0013	1.0876	66.94		13.39
17272	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17273	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17274	Destruction of skin lesions		T	0016	2.6253	161.59	32.68	32.32
17276	Destruction of skin lesions		T	0016	2.6253	161.59	32.68	32.32
17280	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17281	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17282	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17283	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17284	Destruction of skin lesions		T	0016	2.6253	161.59	32.68	32.32
17286	Destruction of skin lesions		T	0015	1.6062	98.86	20.13	19.77
17304	1 stage mohs, up to 5 spec		T	0694	3.4844	214.47	58.14	42.89
17305	2 stage mohs, up to 5 spec		T	0694	3.4844	214.47	58.14	42.89
17306	3 stage mohs, up to 5 spec		T	0694	3.4844	214.47	58.14	42.89
17307	Mohs addl stage up to 5 spec		T	0694	3.4844	214.47	58.14	42.89
17310	Mohs any stage > 5 spec each		T	0694	3.4844	214.47	58.14	42.89
17340	Cryotherapy of skin	CH	T	0016	2.6253	161.59	32.68	32.32
17360	Skin peel therapy		T	0013	1.0876	66.94		13.39
17380	Hair removal by electrolysis		T	0013	1.0876	66.94		13.39
17999	Skin tissue procedure	CH	T	0012	0.8076	49.71	10.30	9.94
19000	Drainage of breast lesion		T	0004	2.0863	128.41		25.68
19001	Drain breast lesion add-on	CH	T	0002	1.0948	67.39		13.48
19020	Incision of breast lesion		T	0008	17.4686	1,075.21		215.04
19030	Injection for breast x-ray		N					
19100	Bx breast percut w/o image		T	0005	3.8051	234.21	71.59	46.84
19101	Biopsy of breast, open		T	0028	19.2250	1,183.32	303.74	236.66
19102	Bx breast percut w/image		T	0005	3.8051	234.21	71.59	46.84
19103	Bx breast percut w/device		T	0658	6.4482	396.89		79.38
19110	Nipple exploration		T	0028	19.2250	1,183.32	303.74	236.66
19112	Excise breast duct fistula		T	0028	19.2250	1,183.32	303.74	236.66
19120	Removal of breast lesion		T	0028	19.2250	1,183.32	303.74	236.66
19125	Excision, breast lesion		T	0028	19.2250	1,183.32	303.74	236.66
19126	Excision, addl breast lesion		T	0028	19.2250	1,183.32	303.74	236.66
19140	Removal of breast tissue		T	0028	19.2250	1,183.32	303.74	236.66
19160	Partial mastectomy		T	0028	19.2250	1,183.32	303.74	236.66
19162	P-mastectomy w/ln removal		T	0693	37.4843	2,307.20	731.74	461.44
19180	Removal of breast		T	0029	28.1505	1,732.69		346.54
19182	Removal of breast		T	0029	28.1505	1,732.69		346.54
19240	Removal of breast		T	0030	40.7495	2,508.17	763.55	501.63
19260	Removal of chest wall lesion		T	0021	14.9563	920.58	219.48	184.12
19290	Place needle wire, breast		N					
19291	Place needle wire, breast		N					
19295	Place breast clip, percut		S	0657	1.7625	108.48		21.70
19296	Place po breast cath for rad	CH	T	0030	40.7495	2,508.17	763.55	501.63
19297	Place breast cath for rad	CH	T	0029	28.1505	1,732.69		346.54
19298	Place breast rad tube/caths		S	1524		3,250.00		650.00
19316	Suspension of breast		T	0029	28.1505	1,732.69		346.54

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
19318	Reduction of large breast		T	0693	37.4843	2,307.20	731.74	461.44
19324	Enlarge breast		T	0693	37.4843	2,307.20	731.74	461.44
19325	Enlarge breast with implant		T	0648	48.7796	3,002.43		600.49
19328	Removal of breast implant		T	0029	28.1505	1,732.69		346.54
19330	Removal of implant material		T	0029	28.1505	1,732.69		346.54
19340	Immediate breast prosthesis		T	0030	40.7495	2,508.17	763.55	501.63
19342	Delayed breast prosthesis		T	0648	48.7796	3,002.43		600.49
19350	Breast reconstruction		T	0028	19.2250	1,183.32	303.74	236.66
19355	Correct inverted nipple(s)		T	0029	28.1505	1,732.69		346.54
19357	Breast reconstruction		T	0648	48.7796	3,002.43		600.49
19366	Breast reconstruction		T	0029	28.1505	1,732.69		346.54
19370	Surgery of breast capsule		T	0029	28.1505	1,732.69		346.54
19371	Removal of breast capsule		T	0029	28.1505	1,732.69		346.54
19380	Revise breast reconstruction		T	0030	40.7495	2,508.17	763.55	501.63
19396	Design custom breast implant		T	0029	28.1505	1,732.69		346.54
19499	Breast surgery procedure		T	0028	19.2250	1,183.32	303.74	236.66
20000	Incision of abscess		T	0006	1.4821	91.22	21.76	18.24
20005	Incision of deep abscess		T	0049	20.8214	1,281.58		256.32
20100	Explore wound, neck		T	0023	4.1133	253.18		50.64
20101	Explore wound, chest		T	0027	21.2645	1,308.85	329.72	261.77
20102	Explore wound, abdomen		T	0027	21.2645	1,308.85	329.72	261.77
20103	Explore wound, extremity		T	0023	4.1133	253.18		50.64
20150	Excise epiphyseal bar		T	0051	41.2543	2,539.24		507.85
20200	Muscle biopsy		T	0021	14.9563	920.58	219.48	184.12
20205	Deep muscle biopsy		T	0021	14.9563	920.58	219.48	184.12
20206	Needle biopsy, muscle		T	0005	3.8051	234.21	71.59	46.84
20220	Bone biopsy, trocar/needle		T	0019	4.0123	246.96	71.87	49.39
20225	Bone biopsy, trocar/needle		T	0020	6.5128	400.87	98.57	80.17
20240	Bone biopsy, excisional		T	0022	19.9760	1,229.54	354.45	245.91
20245	Bone biopsy, excisional		T	0022	19.9760	1,229.54	354.45	245.91
20250	Open bone biopsy		T	0049	20.8214	1,281.58		256.32
20251	Open bone biopsy		T	0049	20.8214	1,281.58		256.32
20500	Injection of sinus tract		T	0251	2.3768	146.29		29.26
20501	Inject sinus tract for x-ray		N					
20520	Removal of foreign body		T	0019	4.0123	246.96	71.87	49.39
20525	Removal of foreign body		T	0022	19.9760	1,229.54	354.45	245.91
20526	Ther injection, carp tunnel		T	0204	2.2491	138.43	40.13	27.69
20550	Inj tendon sheath/ligament		T	0204	2.2491	138.43	40.13	27.69
20551	Inj tendon origin/insertion		T	0204	2.2491	138.43	40.13	27.69
20552	Inj trigger point, 1/2 muscl		T	0204	2.2491	138.43	40.13	27.69
20553	Inject trigger points, =/> 3		T	0204	2.2491	138.43	40.13	27.69
20600	Drain/inject, joint/bursa		T	0204	2.2491	138.43	40.13	27.69
20605	Drain/inject, joint/bursa		T	0204	2.2491	138.43	40.13	27.69
20610	Drain/inject, joint/bursa		T	0204	2.2491	138.43	40.13	27.69
20612	Aspirate/inj ganglion cyst		T	0204	2.2491	138.43	40.13	27.69
20615	Treatment of bone cyst		T	0004	2.0863	128.41		25.68
20650	Insert and remove bone pin		T	0049	20.8214	1,281.58		256.32
20662	Application of pelvis brace		T	0049	20.8214	1,281.58		256.32
20663	Application of thigh brace		T	0049	20.8214	1,281.58		256.32
20665	Removal of fixation device		X	0340	0.6211	38.23		7.65
20670	Removal of support implant		T	0021	14.9563	920.58	219.48	184.12
20680	Removal of support implant		T	0022	19.9760	1,229.54	354.45	245.91
20690	Apply bone fixation device		T	0050	25.0600	1,542.47		308.49
20692	Apply bone fixation device		T	0050	25.0600	1,542.47		308.49
20693	Adjust bone fixation device		T	0049	20.8214	1,281.58		256.32
20694	Remove bone fixation device		T	0049	20.8214	1,281.58		256.32
20822	Replantation digit, complete		T	0054	25.8425	1,590.63		318.13
20900	Removal of bone for graft		T	0050	25.0600	1,542.47		308.49
20902	Removal of bone for graft		T	0050	25.0600	1,542.47		308.49
20910	Remove cartilage for graft		T	0027	21.2645	1,308.85	329.72	261.77
20912	Remove cartilage for graft		T	0027	21.2645	1,308.85	329.72	261.77
20920	Removal of fascia for graft		T	0686	13.3433	821.29		164.26
20922	Removal of fascia for graft		T	0027	21.2645	1,308.85	329.72	261.77
20924	Removal of tendon for graft		T	0050	25.0600	1,542.47		308.49
20926	Removal of tissue for graft		T	0686	13.3433	821.29		164.26
20950	Fluid pressure, muscle		T	0006	1.4821	91.22	21.76	18.24
20972	Bone/skin graft, metatarsal		T	0056	41.2239	2,537.37		507.47
20973	Bone/skin graft, great toe		T	0056	41.2239	2,537.37		507.47
20975	Electrical bone stimulation		X	0340	0.6211	38.23		7.65
20982	Ablate, bone tumor(s) perq	CH	T	0050	25.0600	1,542.47		308.49

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
20999	Musculoskeletal surgery		T	0049	20.8214	1,281.58		256.32
21010	Incision of jaw joint		T	0254	23.1564	1,425.30	321.35	285.06
21015	Resection of facial tumor		T	0253	16.4494	1,012.48	282.29	202.50
21025	Excision of bone, lower jaw		T	0256	37.7719	2,324.90		464.98
21026	Excision of facial bone(s)		T	0256	37.7719	2,324.90		464.98
21029	Contour of face bone lesion		T	0256	37.7719	2,324.90		464.98
21030	Excise max/zygoma b9 tumor		T	0254	23.1564	1,425.30	321.35	285.06
21031	Remove exostosis, mandible		T	0254	23.1564	1,425.30	321.35	285.06
21032	Remove exostosis, maxilla		T	0254	23.1564	1,425.30	321.35	285.06
21034	Excise max/zygoma mlg tumor		T	0256	37.7719	2,324.90		464.98
21040	Excise mandible lesion		T	0254	23.1564	1,425.30	321.35	285.06
21044	Removal of jaw bone lesion		T	0256	37.7719	2,324.90		464.98
21046	Remove mandible cyst complex		T	0256	37.7719	2,324.90		464.98
21047	Excise lwr jaw cyst w/repair		T	0256	37.7719	2,324.90		464.98
21048	Remove maxilla cyst complex		T	0256	37.7719	2,324.90		464.98
21049	Excis uppr jaw cyst w/repair		T	0256	37.7719	2,324.90		464.98
21050	Removal of jaw joint		T	0256	37.7719	2,324.90		464.98
21060	Remove jaw joint cartilage		T	0256	37.7719	2,324.90		464.98
21070	Remove coronoid process		T	0256	37.7719	2,324.90		464.98
21076	Prepare face/oral prosthesis		T	0254	23.1564	1,425.30	321.35	285.06
21077	Prepare face/oral prosthesis		T	0256	37.7719	2,324.90		464.98
21079	Prepare face/oral prosthesis		T	0256	37.7719	2,324.90		464.98
21080	Prepare face/oral prosthesis		T	0256	37.7719	2,324.90		464.98
21081	Prepare face/oral prosthesis		T	0256	37.7719	2,324.90		464.98
21082	Prepare face/oral prosthesis		T	0256	37.7719	2,324.90		464.98
21083	Prepare face/oral prosthesis		T	0256	37.7719	2,324.90		464.98
21084	Prepare face/oral prosthesis		T	0256	37.7719	2,324.90		464.98
21085	Prepare face/oral prosthesis		T	0253	16.4494	1,012.48	282.29	202.50
21086	Prepare face/oral prosthesis		T	0256	37.7719	2,324.90		464.98
21087	Prepare face/oral prosthesis		T	0256	37.7719	2,324.90		464.98
21088	Prepare face/oral prosthesis		T	0256	37.7719	2,324.90		464.98
21089	Prepare face/oral prosthesis		T	0251	2.3768	146.29		29.26
21100	Maxillofacial fixation		T	0256	37.7719	2,324.90		464.98
21110	Interdental fixation		T	0252	7.7261	475.55	111.84	95.11
21116	Injection, jaw joint x-ray		N					
21120	Reconstruction of chin		T	0254	23.1564	1,425.30	321.35	285.06
21121	Reconstruction of chin		T	0254	23.1564	1,425.30	321.35	285.06
21122	Reconstruction of chin		T	0254	23.1564	1,425.30	321.35	285.06
21123	Reconstruction of chin		T	0254	23.1564	1,425.30	321.35	285.06
21125	Augmentation, lower jaw bone		T	0254	23.1564	1,425.30	321.35	285.06
21127	Augmentation, lower jaw bone		T	0256	37.7719	2,324.90		464.98
21137	Reduction of forehead		T	0254	23.1564	1,425.30	321.35	285.06
21138	Reduction of forehead		T	0256	37.7719	2,324.90		464.98
21139	Reduction of forehead		T	0256	37.7719	2,324.90		464.98
21150	Reconstruct midface, lefort		T	0256	37.7719	2,324.90		464.98
21175	Reconstruct orbit/forehead		T	0256	37.7719	2,324.90		464.98
21181	Contour cranial bone lesion		T	0254	23.1564	1,425.30	321.35	285.06
21195	Reconst lwr jaw w/o fixation		T	0256	37.7719	2,324.90		464.98
21198	Reconstr lwr jaw segment		T	0256	37.7719	2,324.90		464.98
21199	Reconstr lwr jaw w/advance		T	0256	37.7719	2,324.90		464.98
21206	Reconstruct upper jaw bone		T	0256	37.7719	2,324.90		464.98
21208	Augmentation of facial bones		T	0256	37.7719	2,324.90		464.98
21209	Reduction of facial bones		T	0256	37.7719	2,324.90		464.98
21210	Face bone graft		T	0256	37.7719	2,324.90		464.98
21215	Lower jaw bone graft		T	0256	37.7719	2,324.90		464.98
21230	Rib cartilage graft		T	0256	37.7719	2,324.90		464.98
21235	Ear cartilage graft		T	0254	23.1564	1,425.30	321.35	285.06
21240	Reconstruction of jaw joint		T	0256	37.7719	2,324.90		464.98
21242	Reconstruction of jaw joint		T	0256	37.7719	2,324.90		464.98
21243	Reconstruction of jaw joint		T	0256	37.7719	2,324.90		464.98
21244	Reconstruction of lower jaw		T	0256	37.7719	2,324.90		464.98
21245	Reconstruction of jaw		T	0256	37.7719	2,324.90		464.98
21246	Reconstruction of jaw		T	0256	37.7719	2,324.90		464.98
21248	Reconstruction of jaw		T	0256	37.7719	2,324.90		464.98
21249	Reconstruction of jaw		T	0256	37.7719	2,324.90		464.98
21260	Revise eye sockets		T	0256	37.7719	2,324.90		464.98
21261	Revise eye sockets		T	0256	37.7719	2,324.90		464.98
21263	Revise eye sockets		T	0256	37.7719	2,324.90		464.98
21267	Revise eye sockets		T	0256	37.7719	2,324.90		464.98
21270	Augmentation, cheek bone		T	0256	37.7719	2,324.90		464.98

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21275	Revision, orbitofacial bones		T	0256	37.7719	2,324.90		464.98
21280	Revision of eyelid		T	0256	37.7719	2,324.90		464.98
21282	Revision of eyelid		T	0253	16.4494	1,012.48	282.29	202.50
21295	Revision of jaw muscle/bone		T	0252	7.7261	475.55	111.84	95.11
21296	Revision of jaw muscle/bone		T	0254	23.1564	1,425.30	321.35	285.06
21299	Cranio/maxillofacial surgery		T	0251	2.3768	146.29		29.26
21300	Treatment of skull fracture		T	0253	16.4494	1,012.48	282.29	202.50
21310	Treatment of nose fracture		T	0251	2.3768	146.29		29.26
21315	Treatment of nose fracture		T	0251	2.3768	146.29		29.26
21320	Treatment of nose fracture		T	0252	7.7261	475.55	111.84	95.11
21325	Treatment of nose fracture		T	0254	23.1564	1,425.30	321.35	285.06
21330	Treatment of nose fracture		T	0254	23.1564	1,425.30	321.35	285.06
21335	Treatment of nose fracture		T	0254	23.1564	1,425.30	321.35	285.06
21336	Treat nasal septal fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
21337	Treat nasal septal fracture		T	0253	16.4494	1,012.48	282.29	202.50
21338	Treat nasoethmoid fracture		T	0254	23.1564	1,425.30	321.35	285.06
21339	Treat nasoethmoid fracture		T	0254	23.1564	1,425.30	321.35	285.06
21340	Treatment of nose fracture		T	0256	37.7719	2,324.90		464.98
21345	Treat nose/jaw fracture		T	0254	23.1564	1,425.30	321.35	285.06
21355	Treat cheek bone fracture		T	0256	37.7719	2,324.90		464.98
21356	Treat cheek bone fracture		T	0254	23.1564	1,425.30	321.35	285.06
21390	Treat eye socket fracture		T	0256	37.7719	2,324.90		464.98
21400	Treat eye socket fracture		T	0252	7.7261	475.55	111.84	95.11
21401	Treat eye socket fracture		T	0253	16.4494	1,012.48	282.29	202.50
21406	Treat eye socket fracture		T	0256	37.7719	2,324.90		464.98
21407	Treat eye socket fracture		T	0256	37.7719	2,324.90		464.98
21408	Treat eye socket fracture		T	0256	37.7719	2,324.90		464.98
21421	Treat mouth roof fracture		T	0254	23.1564	1,425.30	321.35	285.06
21440	Treat dental ridge fracture		T	0254	23.1564	1,425.30	321.35	285.06
21445	Treat dental ridge fracture		T	0254	23.1564	1,425.30	321.35	285.06
21450	Treat lower jaw fracture		T	0251	2.3768	146.29		29.26
21451	Treat lower jaw fracture		T	0252	7.7261	475.55	111.84	95.11
21452	Treat lower jaw fracture		T	0253	16.4494	1,012.48	282.29	202.50
21453	Treat lower jaw fracture		T	0256	37.7719	2,324.90		464.98
21454	Treat lower jaw fracture		T	0254	23.1564	1,425.30	321.35	285.06
21461	Treat lower jaw fracture		T	0256	37.7719	2,324.90		464.98
21462	Treat lower jaw fracture		T	0256	37.7719	2,324.90		464.98
21465	Treat lower jaw fracture		T	0256	37.7719	2,324.90		464.98
21470	Treat lower jaw fracture		T	0256	37.7719	2,324.90		464.98
21480	Reset dislocated jaw		T	0251	2.3768	146.29		29.26
21485	Reset dislocated jaw		T	0253	16.4494	1,012.48	282.29	202.50
21490	Repair dislocated jaw		T	0256	37.7719	2,324.90		464.98
21495	Treat hyoid bone fracture		T	0253	16.4494	1,012.48	282.29	202.50
21497	Interdental wiring		T	0253	16.4494	1,012.48	282.29	202.50
21499	Head surgery procedure		T	0251	2.3768	146.29		29.26
21501	Drain neck/chest lesion		T	0008	17.4686	1,075.21		215.04
21502	Drain chest lesion		T	0049	20.8214	1,281.58		256.32
21550	Biopsy of neck/chest	CH	T	0020	6.5128	400.87	98.57	80.17
21555	Remove lesion, neck/chest		T	0022	19.9760	1,229.54	354.45	245.91
21556	Remove lesion, neck/chest		T	0022	19.9760	1,229.54	354.45	245.91
21557	Remove tumor, neck/chest		T	0022	19.9760	1,229.54	354.45	245.91
21600	Partial removal of rib		T	0050	25.0600	1,542.47		308.49
21610	Partial removal of rib		T	0050	25.0600	1,542.47		308.49
21685	Hyoid myotomy&suspension		T	0252	7.7261	475.55	111.84	95.11
21700	Revision of neck muscle		T	0049	20.8214	1,281.58		256.32
21720	Revision of neck muscle		T	0049	20.8214	1,281.58		256.32
21725	Revision of neck muscle		T	0006	1.4821	91.22	21.76	18.24
21742	Repair stern/nuss w/o scope		T	0051	41.2543	2,539.24		507.85
21743	Repair sternum/nuss w/scope		T	0051	41.2543	2,539.24		507.85
21800	Treatment of rib fracture		T	0043	1.6914	104.11		20.82
21805	Treatment of rib fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
21820	Treat sternum fracture		T	0043	1.6914	104.11		20.82
21899	Neck/chest surgery procedure		T	0251	2.3768	146.29		29.26
21920	Biopsy soft tissue of back		T	0020	6.5128	400.87	98.57	80.17
21925	Biopsy soft tissue of back		T	0022	19.9760	1,229.54	354.45	245.91
21930	Remove lesion, back or flank		T	0022	19.9760	1,229.54	354.45	245.91
21935	Remove tumor, back		T	0022	19.9760	1,229.54	354.45	245.91
22100	Remove part of neck vertebra		T	0208	43.9030	2,702.27		540.45
22101	Remove part, thorax vertebra		T	0208	43.9030	2,702.27		540.45
22102	Remove part, lumbar vertebra		T	0208	43.9030	2,702.27		540.45

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
22103	Remove extra spine segment		T	0208	43.9030	2,702.27		540.45
22222	Revision of thorax spine		T	0208	43.9030	2,702.27		540.45
22305	Treat spine process fracture		T	0043	1.6914	104.11		20.82
22310	Treat spine fracture		T	0043	1.6914	104.11		20.82
22315	Treat spine fracture		T	0043	1.6914	104.11		20.82
22505	Manipulation of spine		T	0045	14.5502	895.58	268.47	179.12
22520	Percut vertebroplasty thor		T	0050	25.0600	1,542.47		308.49
22521	Percut vertebroplasty lumb		T	0050	25.0600	1,542.47		308.49
22522	Percut vertebroplasty add'l		T	0050	25.0600	1,542.47		308.49
22523	Percut kyphoplasty, thor		T	0052	65.8846	4,055.26		811.05
22524	Percut kyphoplasty, lumbar		T	0052	65.8846	4,055.26		811.05
22525	Percut kyphoplasty, add-on		T	0052	65.8846	4,055.26		811.05
22612	Lumbar spine fusion		T	0208	43.9030	2,702.27		540.45
22614	Spine fusion, extra segment		T	0208	43.9030	2,702.27		540.45
22851	Apply spine prosth device	CH	T	0049	20.8214	1,281.58		256.32
22899	Spine surgery procedure	CH	T	0049	20.8214	1,281.58		256.32
22900	Remove abdominal wall lesion		T	0022	19.9760	1,229.54	354.45	245.91
22999	Abdomen surgery procedure	CH	T	0049	20.8214	1,281.58		256.32
23000	Removal of calcium deposits		T	0021	14.9563	920.58	219.48	184.12
23020	Release shoulder joint		T	0051	41.2543	2,539.24		507.85
23030	Drain shoulder lesion		T	0008	17.4686	1,075.21		215.04
23031	Drain shoulder bursa		T	0008	17.4686	1,075.21		215.04
23035	Drain shoulder bone lesion		T	0049	20.8214	1,281.58		256.32
23040	Exploratory shoulder surgery		T	0050	25.0600	1,542.47		308.49
23044	Exploratory shoulder surgery		T	0050	25.0600	1,542.47		308.49
23065	Biopsy shoulder tissues	CH	T	0020	6.5128	400.87	98.57	80.17
23066	Biopsy shoulder tissues		T	0022	19.9760	1,229.54	354.45	245.91
23075	Removal of shoulder lesion		T	0021	14.9563	920.58	219.48	184.12
23076	Removal of shoulder lesion		T	0022	19.9760	1,229.54	354.45	245.91
23077	Remove tumor of shoulder		T	0022	19.9760	1,229.54	354.45	245.91
23100	Biopsy of shoulder joint		T	0049	20.8214	1,281.58		256.32
23101	Shoulder joint surgery		T	0050	25.0600	1,542.47		308.49
23105	Remove shoulder joint lining		T	0050	25.0600	1,542.47		308.49
23106	Incision of collarbone joint		T	0050	25.0600	1,542.47		308.49
23107	Explore treat shoulder joint		T	0050	25.0600	1,542.47		308.49
23120	Partial removal, collar bone		T	0051	41.2543	2,539.24		507.85
23125	Removal of collar bone		T	0051	41.2543	2,539.24		507.85
23130	Remove shoulder bone, part		T	0051	41.2543	2,539.24		507.85
23140	Removal of bone lesion		T	0049	20.8214	1,281.58		256.32
23145	Removal of bone lesion		T	0050	25.0600	1,542.47		308.49
23146	Removal of bone lesion		T	0050	25.0600	1,542.47		308.49
23150	Removal of humerus lesion		T	0050	25.0600	1,542.47		308.49
23155	Removal of humerus lesion		T	0050	25.0600	1,542.47		308.49
23156	Removal of humerus lesion		T	0050	25.0600	1,542.47		308.49
23170	Remove collar bone lesion		T	0050	25.0600	1,542.47		308.49
23172	Remove shoulder blade lesion		T	0050	25.0600	1,542.47		308.49
23174	Remove humerus lesion		T	0050	25.0600	1,542.47		308.49
23180	Remove collar bone lesion		T	0050	25.0600	1,542.47		308.49
23182	Remove shoulder blade lesion		T	0050	25.0600	1,542.47		308.49
23184	Remove humerus lesion		T	0050	25.0600	1,542.47		308.49
23190	Partial removal of scapula		T	0050	25.0600	1,542.47		308.49
23195	Removal of head of humerus		T	0050	25.0600	1,542.47		308.49
23330	Remove shoulder foreign body		T	0020	6.5128	400.87	98.57	80.17
23331	Remove shoulder foreign body		T	0022	19.9760	1,229.54	354.45	245.91
23350	Injection for shoulder x-ray		N					
23395	Muscle transfer,shoulder/arm		T	0051	41.2543	2,539.24		507.85
23397	Muscle transfers		T	0052	65.8846	4,055.26		811.05
23400	Fixation of shoulder blade		T	0050	25.0600	1,542.47		308.49
23405	Incision of tendon&muscle		T	0050	25.0600	1,542.47		308.49
23406	Incise tendon(s)&muscle(s)		T	0050	25.0600	1,542.47		308.49
23410	Repair rotator cuff, acute	CH	T	0051	41.2543	2,539.24		507.85
23412	Repair rotator cuff, chronic	CH	T	0051	41.2543	2,539.24		507.85
23415	Release of shoulder ligament		T	0051	41.2543	2,539.24		507.85
23420	Repair of shoulder	CH	T	0051	41.2543	2,539.24		507.85
23430	Repair biceps tendon	CH	T	0051	41.2543	2,539.24		507.85
23440	Remove/transplant tendon	CH	T	0051	41.2543	2,539.24		507.85
23450	Repair shoulder capsule		T	0052	65.8846	4,055.26		811.05
23455	Repair shoulder capsule		T	0052	65.8846	4,055.26		811.05
23460	Repair shoulder capsule		T	0052	65.8846	4,055.26		811.05
23462	Repair shoulder capsule	CH	T	0051	41.2543	2,539.24		507.85

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23465	Repair shoulder capsule		T	0052	65.8846	4,055.26		811.05
23466	Repair shoulder capsule	CH	T	0051	41.2543	2,539.24		507.85
23470	Reconstruct shoulder joint		T	0425	105.1666	6,473.11	1,378.01	1,294.62
23480	Revision of collar bone		T	0051	41.2543	2,539.24		507.85
23485	Revision of collar bone	CH	T	0052	65.8846	4,055.26		811.05
23490	Reinforce clavicle		T	0051	41.2543	2,539.24		507.85
23491	Reinforce shoulder bones	CH	T	0052	65.8846	4,055.26		811.05
23500	Treat clavicle fracture		T	0043	1.6914	104.11		20.82
23505	Treat clavicle fracture		T	0043	1.6914	104.11		20.82
23515	Treat clavicle fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
23520	Treat clavicle dislocation		T	0043	1.6914	104.11		20.82
23525	Treat clavicle dislocation		T	0043	1.6914	104.11		20.82
23530	Treat clavicle dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
23532	Treat clavicle dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
23540	Treat clavicle dislocation		T	0043	1.6914	104.11		20.82
23545	Treat clavicle dislocation		T	0043	1.6914	104.11		20.82
23550	Treat clavicle dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
23552	Treat clavicle dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
23570	Treat shoulder blade fx		T	0043	1.6914	104.11		20.82
23575	Treat shoulder blade fx		T	0043	1.6914	104.11		20.82
23585	Treat scapula fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
23600	Treat humerus fracture		T	0043	1.6914	104.11		20.82
23605	Treat humerus fracture		T	0043	1.6914	104.11		20.82
23615	Treat humerus fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
23616	Treat humerus fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
23620	Treat humerus fracture		T	0043	1.6914	104.11		20.82
23625	Treat humerus fracture		T	0043	1.6914	104.11		20.82
23630	Treat humerus fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
23650	Treat shoulder dislocation		T	0043	1.6914	104.11		20.82
23655	Treat shoulder dislocation		T	0045	14.5502	895.58	268.47	179.12
23660	Treat shoulder dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
23665	Treat dislocation/fracture		T	0043	1.6914	104.11		20.82
23670	Treat dislocation/fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
23675	Treat dislocation/fracture		T	0043	1.6914	104.11		20.82
23680	Treat dislocation/fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
23700	Fixation of shoulder		T	0045	14.5502	895.58	268.47	179.12
23800	Fusion of shoulder joint	CH	T	0052	65.8846	4,055.26		811.05
23802	Fusion of shoulder joint		T	0051	41.2543	2,539.24		507.85
23921	Amputation follow-up surgery		T	0025	5.0931	313.49	95.46	62.70
23929	Shoulder surgery procedure		T	0043	1.6914	104.11		20.82
23930	Drainage of arm lesion		T	0008	17.4686	1,075.21		215.04
23931	Drainage of arm bursa		T	0008	17.4686	1,075.21		215.04
23935	Drain arm/elbow bone lesion		T	0049	20.8214	1,281.58		256.32
24000	Exploratory elbow surgery		T	0050	25.0600	1,542.47		308.49
24006	Release elbow joint		T	0050	25.0600	1,542.47		308.49
24065	Biopsy arm/elbow soft tissue		T	0021	14.9563	920.58	219.48	184.12
24066	Biopsy arm/elbow soft tissue		T	0021	14.9563	920.58	219.48	184.12
24075	Remove arm/elbow lesion		T	0021	14.9563	920.58	219.48	184.12
24076	Remove arm/elbow lesion		T	0022	19.9760	1,229.54	354.45	245.91
24077	Remove tumor of arm/elbow		T	0022	19.9760	1,229.54	354.45	245.91
24100	Biopsy elbow joint lining		T	0049	20.8214	1,281.58		256.32
24101	Explore/treat elbow joint		T	0050	25.0600	1,542.47		308.49
24102	Remove elbow joint lining		T	0050	25.0600	1,542.47		308.49
24105	Removal of elbow bursa		T	0049	20.8214	1,281.58		256.32
24110	Remove humerus lesion		T	0049	20.8214	1,281.58		256.32
24115	Remove/graft bone lesion		T	0050	25.0600	1,542.47		308.49
24116	Remove/graft bone lesion		T	0050	25.0600	1,542.47		308.49
24120	Remove elbow lesion		T	0049	20.8214	1,281.58		256.32
24125	Remove/graft bone lesion		T	0050	25.0600	1,542.47		308.49
24126	Remove/graft bone lesion		T	0050	25.0600	1,542.47		308.49
24130	Removal of head of radius		T	0050	25.0600	1,542.47		308.49
24134	Removal of arm bone lesion		T	0050	25.0600	1,542.47		308.49
24136	Remove radius bone lesion		T	0050	25.0600	1,542.47		308.49
24138	Remove elbow bone lesion		T	0050	25.0600	1,542.47		308.49
24140	Partial removal of arm bone		T	0050	25.0600	1,542.47		308.49
24145	Partial removal of radius		T	0050	25.0600	1,542.47		308.49
24147	Partial removal of elbow		T	0050	25.0600	1,542.47		308.49
24149	Radical resection of elbow		T	0050	25.0600	1,542.47		308.49
24150	Extensive humerus surgery	CH	T	0051	41.2543	2,539.24		507.85
24151	Extensive humerus surgery		T	0052	65.8846	4,055.26		811.05

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24152	Extensive radius surgery	CH	T	0051	41.2543	2,539.24		507.85
24153	Extensive radius surgery		T	0052	65.8846	4,055.26		811.05
24155	Removal of elbow joint		T	0051	41.2543	2,539.24		507.85
24160	Remove elbow joint implant		T	0050	25.0600	1,542.47		308.49
24164	Remove radius head implant		T	0050	25.0600	1,542.47		308.49
24200	Removal of arm foreign body		T	0019	4.0123	246.96	71.87	49.39
24201	Removal of arm foreign body		T	0021	14.9563	920.58	219.48	184.12
24220	Injection for elbow x-ray		N					
24300	Manipulate elbow w/anesth		T	0045	14.5502	895.58	268.47	179.12
24301	Muscle/tendon transfer		T	0050	25.0600	1,542.47		308.49
24305	Arm tendon lengthening		T	0050	25.0600	1,542.47		308.49
24310	Revision of arm tendon		T	0049	20.8214	1,281.58		256.32
24320	Repair of arm tendon		T	0051	41.2543	2,539.24		507.85
24330	Revision of arm muscles	CH	T	0052	65.8846	4,055.26		811.05
24331	Revision of arm muscles		T	0051	41.2543	2,539.24		507.85
24332	Tenolysis, triceps		T	0049	20.8214	1,281.58		256.32
24340	Repair of biceps tendon		T	0051	41.2543	2,539.24		507.85
24341	Repair arm tendon/muscle		T	0051	41.2543	2,539.24		507.85
24342	Repair of ruptured tendon		T	0051	41.2543	2,539.24		507.85
24343	Repr elbow lat ligmnt w/tiss		T	0050	25.0600	1,542.47		308.49
24344	Reconstruct elbow lat ligmnt	CH	T	0052	65.8846	4,055.26		811.05
24345	Repr elbw med ligmnt w/tissu		T	0050	25.0600	1,542.47		308.49
24346	Reconstruct elbow med ligmnt		T	0051	41.2543	2,539.24		507.85
24350	Repair of tennis elbow		T	0050	25.0600	1,542.47		308.49
24351	Repair of tennis elbow		T	0050	25.0600	1,542.47		308.49
24352	Repair of tennis elbow		T	0050	25.0600	1,542.47		308.49
24354	Repair of tennis elbow		T	0050	25.0600	1,542.47		308.49
24356	Revision of tennis elbow		T	0050	25.0600	1,542.47		308.49
24360	Reconstruct elbow joint		T	0047	32.7543	2,016.06	537.03	403.21
24361	Reconstruct elbow joint		T	0425	105.1666	6,473.11	1,378.01	1,294.62
24362	Reconstruct elbow joint		T	0048	47.1644	2,903.02		580.60
24363	Replace elbow joint		T	0425	105.1666	6,473.11	1,378.01	1,294.62
24365	Reconstruct head of radius		T	0047	32.7543	2,016.06	537.03	403.21
24366	Reconstruct head of radius		T	0425	105.1666	6,473.11	1,378.01	1,294.62
24400	Revision of humerus		T	0050	25.0600	1,542.47		308.49
24410	Revision of humerus		T	0050	25.0600	1,542.47		308.49
24420	Revision of humerus		T	0051	41.2543	2,539.24		507.85
24430	Repair of humerus	CH	T	0052	65.8846	4,055.26		811.05
24435	Repair humerus with graft	CH	T	0052	65.8846	4,055.26		811.05
24470	Revision of elbow joint		T	0051	41.2543	2,539.24		507.85
24495	Decompression of forearm		T	0050	25.0600	1,542.47		308.49
24498	Reinforce humerus	CH	T	0052	65.8846	4,055.26		811.05
24500	Treat humerus fracture		T	0043	1.6914	104.11		20.82
24505	Treat humerus fracture		T	0043	1.6914	104.11		20.82
24515	Treat humerus fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
24516	Treat humerus fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
24530	Treat humerus fracture		T	0043	1.6914	104.11		20.82
24535	Treat humerus fracture		T	0043	1.6914	104.11		20.82
24538	Treat humerus fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
24545	Treat humerus fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
24546	Treat humerus fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
24560	Treat humerus fracture		T	0043	1.6914	104.11		20.82
24565	Treat humerus fracture		T	0043	1.6914	104.11		20.82
24566	Treat humerus fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
24575	Treat humerus fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
24576	Treat humerus fracture		T	0043	1.6914	104.11		20.82
24577	Treat humerus fracture		T	0043	1.6914	104.11		20.82
24579	Treat humerus fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
24582	Treat humerus fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
24586	Treat elbow fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
24587	Treat elbow fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
24600	Treat elbow dislocation		T	0043	1.6914	104.11		20.82
24605	Treat elbow dislocation		T	0045	14.5502	895.58	268.47	179.12
24615	Treat elbow dislocation	CH	T	0064	56.4195	3,472.68	825.22	694.54
24620	Treat elbow fracture		T	0043	1.6914	104.11		20.82
24635	Treat elbow fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
24640	Treat elbow dislocation		T	0043	1.6914	104.11		20.82
24650	Treat radius fracture		T	0043	1.6914	104.11		20.82
24655	Treat radius fracture		T	0043	1.6914	104.11		20.82
24665	Treat radius fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24666	Treat radius fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
24670	Treat ulnar fracture		T	0043	1.6914	104.11		20.82
24675	Treat ulnar fracture		T	0043	1.6914	104.11		20.82
24685	Treat ulnar fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
24800	Fusion of elbow joint		T	0051	41.2543	2,539.24		507.85
24802	Fusion/graft of elbow joint		T	0051	41.2543	2,539.24		507.85
24925	Amputation follow-up surgery		T	0049	20.8214	1,281.58		256.32
24935	Revision of amputation		T	0052	65.8846	4,055.26		811.05
24999	Upper arm/elbow surgery		T	0043	1.6914	104.11		20.82
25000	Incision of tendon sheath		T	0049	20.8214	1,281.58		256.32
25001	Incise flexor carpi radialis		T	0049	20.8214	1,281.58		256.32
25020	Decompress forearm 1 space		T	0049	20.8214	1,281.58		256.32
25023	Decompress forearm 1 space		T	0050	25.0600	1,542.47		308.49
25024	Decompress forearm 2 spaces		T	0050	25.0600	1,542.47		308.49
25025	Decompress forearm 2 spaces		T	0050	25.0600	1,542.47		308.49
25028	Drainage of forearm lesion		T	0049	20.8214	1,281.58		256.32
25031	Drainage of forearm bursa		T	0049	20.8214	1,281.58		256.32
25035	Treat forearm bone lesion		T	0049	20.8214	1,281.58		256.32
25040	Explore/treat wrist joint		T	0050	25.0600	1,542.47		308.49
25065	Biopsy forearm soft tissues	CH	T	0020	6.5128	400.87	98.57	80.17
25066	Biopsy forearm soft tissues		T	0022	19.9760	1,229.54	354.45	245.91
25075	Removal forearm lesion subcu		T	0021	14.9563	920.58	219.48	184.12
25076	Removal forearm lesion deep		T	0022	19.9760	1,229.54	354.45	245.91
25077	Remove tumor, forearm/wrist		T	0022	19.9760	1,229.54	354.45	245.91
25085	Incision of wrist capsule		T	0049	20.8214	1,281.58		256.32
25100	Biopsy of wrist joint		T	0049	20.8214	1,281.58		256.32
25101	Explore/treat wrist joint		T	0050	25.0600	1,542.47		308.49
25105	Remove wrist joint lining		T	0050	25.0600	1,542.47		308.49
25107	Remove wrist joint cartilage		T	0050	25.0600	1,542.47		308.49
25110	Remove wrist tendon lesion		T	0049	20.8214	1,281.58		256.32
25111	Remove wrist tendon lesion		T	0053	16.0343	986.93	253.49	197.39
25112	Reremove wrist tendon lesion		T	0053	16.0343	986.93	253.49	197.39
25115	Remove wrist/forearm lesion		T	0049	20.8214	1,281.58		256.32
25116	Remove wrist/forearm lesion		T	0049	20.8214	1,281.58		256.32
25118	Excise wrist tendon sheath		T	0050	25.0600	1,542.47		308.49
25119	Partial removal of ulna		T	0050	25.0600	1,542.47		308.49
25120	Removal of forearm lesion		T	0050	25.0600	1,542.47		308.49
25125	Remove/graft forearm lesion		T	0050	25.0600	1,542.47		308.49
25126	Remove/graft forearm lesion		T	0050	25.0600	1,542.47		308.49
25130	Removal of wrist lesion		T	0050	25.0600	1,542.47		308.49
25135	Remove&graft wrist lesion		T	0050	25.0600	1,542.47		308.49
25136	Remove&graft wrist lesion		T	0050	25.0600	1,542.47		308.49
25145	Remove forearm bone lesion		T	0050	25.0600	1,542.47		308.49
25150	Partial removal of ulna		T	0050	25.0600	1,542.47		308.49
25151	Partial removal of radius		T	0050	25.0600	1,542.47		308.49
25170	Extensive forearm surgery	CH	T	0051	41.2543	2,539.24		507.85
25210	Removal of wrist bone		T	0054	25.8425	1,590.63		318.13
25215	Removal of wrist bones		T	0054	25.8425	1,590.63		318.13
25230	Partial removal of radius		T	0050	25.0600	1,542.47		308.49
25240	Partial removal of ulna		T	0050	25.0600	1,542.47		308.49
25246	Injection for wrist x-ray		N					
25248	Remove forearm foreign body		T	0049	20.8214	1,281.58		256.32
25250	Removal of wrist prosthesis		T	0050	25.0600	1,542.47		308.49
25251	Removal of wrist prosthesis		T	0050	25.0600	1,542.47		308.49
25259	Manipulate wrist w/anesthes		T	0043	1.6914	104.11		20.82
25260	Repair forearm tendon/muscle		T	0050	25.0600	1,542.47		308.49
25263	Repair forearm tendon/muscle		T	0050	25.0600	1,542.47		308.49
25265	Repair forearm tendon/muscle		T	0050	25.0600	1,542.47		308.49
25270	Repair forearm tendon/muscle		T	0050	25.0600	1,542.47		308.49
25272	Repair forearm tendon/muscle		T	0050	25.0600	1,542.47		308.49
25274	Repair forearm tendon/muscle		T	0050	25.0600	1,542.47		308.49
25275	Repair forearm tendon sheath		T	0050	25.0600	1,542.47		308.49
25280	Revise wrist/forearm tendon		T	0050	25.0600	1,542.47		308.49
25290	Incise wrist/forearm tendon		T	0050	25.0600	1,542.47		308.49
25295	Release wrist/forearm tendon		T	0049	20.8214	1,281.58		256.32
25300	Fusion of tendons at wrist		T	0050	25.0600	1,542.47		308.49
25301	Fusion of tendons at wrist		T	0050	25.0600	1,542.47		308.49
25310	Transplant forearm tendon		T	0051	41.2543	2,539.24		507.85
25312	Transplant forearm tendon		T	0051	41.2543	2,539.24		507.85
25315	Revise palsy hand tendon(s)		T	0051	41.2543	2,539.24		507.85

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25316	Revise palsy hand tendon(s)	CH	T	0052	65.8846	4,055.26		811.05
25320	Repair/revise wrist joint		T	0051	41.2543	2,539.24		507.85
25332	Revise wrist joint		T	0047	32.7543	2,016.06	537.03	403.21
25335	Realignment of hand		T	0051	41.2543	2,539.24		507.85
25337	Reconstruct ulna/radioulnar		T	0051	41.2543	2,539.24		507.85
25350	Revision of radius	CH	T	0052	65.8846	4,055.26		811.05
25355	Revision of radius		T	0051	41.2543	2,539.24		507.85
25360	Revision of ulna		T	0050	25.0600	1,542.47		308.49
25365	Revise radius&ulna		T	0050	25.0600	1,542.47		308.49
25370	Revise radius or ulna		T	0051	41.2543	2,539.24		507.85
25375	Revise radius&ulna		T	0051	41.2543	2,539.24		507.85
25390	Shorten radius or ulna		T	0050	25.0600	1,542.47		308.49
25391	Lengthen radius or ulna		T	0051	41.2543	2,539.24		507.85
25392	Shorten radius&ulna		T	0050	25.0600	1,542.47		308.49
25393	Lengthen radius&ulna		T	0051	41.2543	2,539.24		507.85
25394	Repair carpal bone, shorten		T	0053	16.0343	986.93	253.49	197.39
25400	Repair radius or ulna		T	0050	25.0600	1,542.47		308.49
25405	Repair/graft radius or ulna		T	0050	25.0600	1,542.47		308.49
25415	Repair radius&ulna		T	0050	25.0600	1,542.47		308.49
25420	Repair/graft radius&ulna	CH	T	0052	65.8846	4,055.26		811.05
25425	Repair/graft radius or ulna		T	0051	41.2543	2,539.24		507.85
25426	Repair/graft radius&ulna		T	0051	41.2543	2,539.24		507.85
25430	Vasc graft into carpal bone		T	0054	25.8425	1,590.63		318.13
25431	Repair nonunion carpal bone		T	0054	25.8425	1,590.63		318.13
25440	Repair/graft wrist bone	CH	T	0052	65.8846	4,055.26		811.05
25441	Reconstruct wrist joint		T	0425	105.1666	6,473.11	1,378.01	1,294.62
25442	Reconstruct wrist joint		T	0425	105.1666	6,473.11	1,378.01	1,294.62
25443	Reconstruct wrist joint		T	0048	47.1644	2,903.02		580.60
25444	Reconstruct wrist joint		T	0048	47.1644	2,903.02		580.60
25445	Reconstruct wrist joint		T	0048	47.1644	2,903.02		580.60
25446	Wrist replacement		T	0425	105.1666	6,473.11	1,378.01	1,294.62
25447	Repair wrist joint(s)		T	0047	32.7543	2,016.06	537.03	403.21
25449	Remove wrist joint implant		T	0047	32.7543	2,016.06	537.03	403.21
25450	Revision of wrist joint		T	0051	41.2543	2,539.24		507.85
25455	Revision of wrist joint		T	0051	41.2543	2,539.24		507.85
25490	Reinforce radius		T	0051	41.2543	2,539.24		507.85
25491	Reinforce ulna		T	0051	41.2543	2,539.24		507.85
25492	Reinforce radius and ulna		T	0051	41.2543	2,539.24		507.85
25500	Treat fracture of radius		T	0043	1.6914	104.11		20.82
25505	Treat fracture of radius		T	0043	1.6914	104.11		20.82
25515	Treat fracture of radius	CH	T	0063	37.5680	2,312.35	549.49	462.47
25520	Treat fracture of radius		T	0043	1.6914	104.11		20.82
25525	Treat fracture of radius	CH	T	0063	37.5680	2,312.35	549.49	462.47
25526	Treat fracture of radius	CH	T	0063	37.5680	2,312.35	549.49	462.47
25530	Treat fracture of ulna		T	0043	1.6914	104.11		20.82
25535	Treat fracture of ulna		T	0043	1.6914	104.11		20.82
25545	Treat fracture of ulna	CH	T	0063	37.5680	2,312.35	549.49	462.47
25560	Treat fracture radius&ulna		T	0043	1.6914	104.11		20.82
25565	Treat fracture radius&ulna		T	0043	1.6914	104.11		20.82
25574	Treat fracture radius&ulna	CH	T	0064	56.4195	3,472.68	825.22	694.54
25575	Treat fracture radius/ulna	CH	T	0064	56.4195	3,472.68	825.22	694.54
25600	Treat fracture radius/ulna		T	0043	1.6914	104.11		20.82
25605	Treat fracture radius/ulna		T	0043	1.6914	104.11		20.82
25611	Treat fracture radius/ulna	CH	T	0062	25.6702	1,580.03	375.46	316.01
25620	Treat fracture radius/ulna	CH	T	0064	56.4195	3,472.68	825.22	694.54
25622	Treat wrist bone fracture		T	0043	1.6914	104.11		20.82
25624	Treat wrist bone fracture		T	0043	1.6914	104.11		20.82
25628	Treat wrist bone fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
25630	Treat wrist bone fracture		T	0043	1.6914	104.11		20.82
25635	Treat wrist bone fracture		T	0043	1.6914	104.11		20.82
25645	Treat wrist bone fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
25650	Treat wrist bone fracture		T	0043	1.6914	104.11		20.82
25651	Pin ulnar styloid fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
25652	Treat fracture ulnar styloid	CH	T	0063	37.5680	2,312.35	549.49	462.47
25660	Treat wrist dislocation		T	0043	1.6914	104.11		20.82
25670	Treat wrist dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
25671	Pin radioulnar dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
25675	Treat wrist dislocation		T	0043	1.6914	104.11		20.82
25676	Treat wrist dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
25680	Treat wrist fracture		T	0043	1.6914	104.11		20.82

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25685	Treat wrist fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
25690	Treat wrist dislocation		T	0043	1.6914	104.11		20.82
25695	Treat wrist dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
25800	Fusion of wrist joint	CH	T	0052	65.8846	4,055.26		811.05
25805	Fusion/graft of wrist joint		T	0051	41.2543	2,539.24		507.85
25810	Fusion/graft of wrist joint	CH	T	0052	65.8846	4,055.26		811.05
25820	Fusion of hand bones		T	0053	16.0343	986.93	253.49	197.39
25825	Fuse hand bones with graft		T	0054	25.8425	1,590.63		318.13
25830	Fusion, radioulnar jnt/ulna	CH	T	0052	65.8846	4,055.26		811.05
25907	Amputation follow-up surgery		T	0049	20.8214	1,281.58		256.32
25922	Amputate hand at wrist		T	0049	20.8214	1,281.58		256.32
25929	Amputation follow-up surgery		T	0686	13.3433	821.29		164.26
25999	Forearm or wrist surgery		T	0043	1.6914	104.11		20.82
26010	Drainage of finger abscess		T	0006	1.4821	91.22	21.76	18.24
26011	Drainage of finger abscess		T	0007	10.9184	672.04		134.41
26020	Drain hand tendon sheath		T	0053	16.0343	986.93	253.49	197.39
26025	Drainage of palm bursa		T	0053	16.0343	986.93	253.49	197.39
26030	Drainage of palm bursa(s)		T	0053	16.0343	986.93	253.49	197.39
26034	Treat hand bone lesion		T	0053	16.0343	986.93	253.49	197.39
26035	Decompress fingers/hand		T	0053	16.0343	986.93	253.49	197.39
26037	Decompress fingers/hand		T	0053	16.0343	986.93	253.49	197.39
26040	Release palm contracture		T	0054	25.8425	1,590.63		318.13
26045	Release palm contracture		T	0054	25.8425	1,590.63		318.13
26055	Incise finger tendon sheath		T	0053	16.0343	986.93	253.49	197.39
26060	Incision of finger tendon		T	0053	16.0343	986.93	253.49	197.39
26070	Explore/treat hand joint		T	0053	16.0343	986.93	253.49	197.39
26075	Explore/treat finger joint		T	0053	16.0343	986.93	253.49	197.39
26080	Explore/treat finger joint		T	0053	16.0343	986.93	253.49	197.39
26100	Biopsy hand joint lining		T	0053	16.0343	986.93	253.49	197.39
26105	Biopsy finger joint lining		T	0053	16.0343	986.93	253.49	197.39
26110	Biopsy finger joint lining		T	0053	16.0343	986.93	253.49	197.39
26115	Removal hand lesion subcut		T	0022	19.9760	1,229.54	354.45	245.91
26116	Removal hand lesion, deep		T	0022	19.9760	1,229.54	354.45	245.91
26117	Remove tumor, hand/finger		T	0022	19.9760	1,229.54	354.45	245.91
26121	Release palm contracture		T	0054	25.8425	1,590.63		318.13
26123	Release palm contracture		T	0054	25.8425	1,590.63		318.13
26125	Release palm contracture		T	0053	16.0343	986.93	253.49	197.39
26130	Remove wrist joint lining		T	0053	16.0343	986.93	253.49	197.39
26135	Revise finger joint, each		T	0054	25.8425	1,590.63		318.13
26140	Revise finger joint, each		T	0053	16.0343	986.93	253.49	197.39
26145	Tendon excision, palm/finger		T	0053	16.0343	986.93	253.49	197.39
26160	Remove tendon sheath lesion		T	0053	16.0343	986.93	253.49	197.39
26170	Removal of palm tendon, each		T	0053	16.0343	986.93	253.49	197.39
26180	Removal of finger tendon		T	0053	16.0343	986.93	253.49	197.39
26185	Remove finger bone		T	0053	16.0343	986.93	253.49	197.39
26200	Remove hand bone lesion		T	0053	16.0343	986.93	253.49	197.39
26205	Remove/graft bone lesion		T	0054	25.8425	1,590.63		318.13
26210	Removal of finger lesion		T	0053	16.0343	986.93	253.49	197.39
26215	Remove/graft finger lesion		T	0053	16.0343	986.93	253.49	197.39
26230	Partial removal of hand bone		T	0053	16.0343	986.93	253.49	197.39
26235	Partial removal, finger bone		T	0053	16.0343	986.93	253.49	197.39
26236	Partial removal, finger bone		T	0053	16.0343	986.93	253.49	197.39
26250	Extensive hand surgery		T	0053	16.0343	986.93	253.49	197.39
26255	Extensive hand surgery		T	0054	25.8425	1,590.63		318.13
26260	Extensive finger surgery		T	0053	16.0343	986.93	253.49	197.39
26261	Extensive finger surgery		T	0053	16.0343	986.93	253.49	197.39
26262	Partial removal of finger		T	0053	16.0343	986.93	253.49	197.39
26320	Removal of implant from hand		T	0021	14.9563	920.58	219.48	184.12
26340	Manipulate finger w/anesth		T	0043	1.6914	104.11		20.82
26350	Repair finger/hand tendon		T	0054	25.8425	1,590.63		318.13
26352	Repair/graft hand tendon		T	0054	25.8425	1,590.63		318.13
26356	Repair finger/hand tendon		T	0054	25.8425	1,590.63		318.13
26357	Repair finger/hand tendon		T	0054	25.8425	1,590.63		318.13
26358	Repair/graft hand tendon		T	0054	25.8425	1,590.63		318.13
26370	Repair finger/hand tendon		T	0054	25.8425	1,590.63		318.13
26372	Repair/graft hand tendon		T	0054	25.8425	1,590.63		318.13
26373	Repair finger/hand tendon		T	0054	25.8425	1,590.63		318.13
26390	Revise hand/finger tendon		T	0054	25.8425	1,590.63		318.13
26392	Repair/graft hand tendon		T	0054	25.8425	1,590.63		318.13
26410	Repair hand tendon		T	0053	16.0343	986.93	253.49	197.39

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26412	Repair/graft hand tendon		T	0054	25.8425	1,590.63		318.13
26415	Excision, hand/finger tendon		T	0054	25.8425	1,590.63		318.13
26416	Graft hand or finger tendon		T	0054	25.8425	1,590.63		318.13
26418	Repair finger tendon		T	0053	16.0343	986.93	253.49	197.39
26420	Repair/graft finger tendon		T	0054	25.8425	1,590.63		318.13
26426	Repair finger/hand tendon		T	0054	25.8425	1,590.63		318.13
26428	Repair/graft finger tendon		T	0054	25.8425	1,590.63		318.13
26432	Repair finger tendon		T	0053	16.0343	986.93	253.49	197.39
26433	Repair finger tendon		T	0053	16.0343	986.93	253.49	197.39
26434	Repair/graft finger tendon		T	0054	25.8425	1,590.63		318.13
26437	Realignment of tendons		T	0053	16.0343	986.93	253.49	197.39
26440	Release palm/finger tendon		T	0053	16.0343	986.93	253.49	197.39
26442	Release palm&finger tendon		T	0054	25.8425	1,590.63		318.13
26445	Release hand/finger tendon		T	0053	16.0343	986.93	253.49	197.39
26449	Release forearm/hand tendon		T	0054	25.8425	1,590.63		318.13
26450	Incision of palm tendon		T	0053	16.0343	986.93	253.49	197.39
26455	Incision of finger tendon		T	0053	16.0343	986.93	253.49	197.39
26460	Incise hand/finger tendon		T	0053	16.0343	986.93	253.49	197.39
26471	Fusion of finger tendons		T	0053	16.0343	986.93	253.49	197.39
26474	Fusion of finger tendons		T	0053	16.0343	986.93	253.49	197.39
26476	Tendon lengthening		T	0053	16.0343	986.93	253.49	197.39
26477	Tendon shortening		T	0053	16.0343	986.93	253.49	197.39
26478	Lengthening of hand tendon		T	0053	16.0343	986.93	253.49	197.39
26479	Shortening of hand tendon		T	0053	16.0343	986.93	253.49	197.39
26480	Transplant hand tendon		T	0054	25.8425	1,590.63		318.13
26483	Transplant/graft hand tendon		T	0054	25.8425	1,590.63		318.13
26485	Transplant palm tendon		T	0054	25.8425	1,590.63		318.13
26489	Transplant/graft palm tendon		T	0054	25.8425	1,590.63		318.13
26490	Revise thumb tendon		T	0054	25.8425	1,590.63		318.13
26492	Tendon transfer with graft		T	0054	25.8425	1,590.63		318.13
26494	Hand tendon/muscle transfer		T	0054	25.8425	1,590.63		318.13
26496	Revise thumb tendon		T	0054	25.8425	1,590.63		318.13
26497	Finger tendon transfer		T	0054	25.8425	1,590.63		318.13
26498	Finger tendon transfer		T	0054	25.8425	1,590.63		318.13
26499	Revision of finger		T	0054	25.8425	1,590.63		318.13
26500	Hand tendon reconstruction		T	0053	16.0343	986.93	253.49	197.39
26502	Hand tendon reconstruction		T	0054	25.8425	1,590.63		318.13
26504	Hand tendon reconstruction		T	0054	25.8425	1,590.63		318.13
26508	Release thumb contracture		T	0053	16.0343	986.93	253.49	197.39
26510	Thumb tendon transfer		T	0054	25.8425	1,590.63		318.13
26516	Fusion of knuckle joint		T	0054	25.8425	1,590.63		318.13
26517	Fusion of knuckle joints		T	0054	25.8425	1,590.63		318.13
26518	Fusion of knuckle joints		T	0054	25.8425	1,590.63		318.13
26520	Release knuckle contracture		T	0053	16.0343	986.93	253.49	197.39
26525	Release finger contracture		T	0053	16.0343	986.93	253.49	197.39
26530	Revise knuckle joint		T	0047	32.7543	2,016.06	537.03	403.21
26531	Revise knuckle with implant		T	0048	47.1644	2,903.02		580.60
26535	Revise finger joint		T	0047	32.7543	2,016.06	537.03	403.21
26536	Revise/implant finger joint		T	0048	47.1644	2,903.02		580.60
26540	Repair hand joint		T	0053	16.0343	986.93	253.49	197.39
26541	Repair hand joint with graft		T	0054	25.8425	1,590.63		318.13
26542	Repair hand joint with graft		T	0053	16.0343	986.93	253.49	197.39
26545	Reconstruct finger joint		T	0054	25.8425	1,590.63		318.13
26546	Repair nonunion hand		T	0054	25.8425	1,590.63		318.13
26548	Reconstruct finger joint		T	0054	25.8425	1,590.63		318.13
26550	Construct thumb replacement		T	0054	25.8425	1,590.63		318.13
26555	Positional change of finger		T	0054	25.8425	1,590.63		318.13
26560	Repair of web finger		T	0053	16.0343	986.93	253.49	197.39
26561	Repair of web finger		T	0054	25.8425	1,590.63		318.13
26562	Repair of web finger		T	0054	25.8425	1,590.63		318.13
26565	Correct metacarpal flaw		T	0054	25.8425	1,590.63		318.13
26567	Correct finger deformity		T	0054	25.8425	1,590.63		318.13
26568	Lengthen metacarpal/finger		T	0054	25.8425	1,590.63		318.13
26580	Repair hand deformity		T	0053	16.0343	986.93	253.49	197.39
26587	Reconstruct extra finger		T	0053	16.0343	986.93	253.49	197.39
26590	Repair finger deformity		T	0053	16.0343	986.93	253.49	197.39
26591	Repair muscles of hand		T	0054	25.8425	1,590.63		318.13
26593	Release muscles of hand		T	0053	16.0343	986.93	253.49	197.39
26596	Excision constricting tissue		T	0053	16.0343	986.93	253.49	197.39
26600	Treat metacarpal fracture		T	0043	1.6914	104.11		20.82

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26605	Treat metacarpal fracture		T	0043	1.6914	104.11		20.82
26607	Treat metacarpal fracture		T	0043	1.6914	104.11		20.82
26608	Treat metacarpal fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
26615	Treat metacarpal fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
26641	Treat thumb dislocation		T	0043	1.6914	104.11		20.82
26645	Treat thumb fracture		T	0043	1.6914	104.11		20.82
26650	Treat thumb fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
26665	Treat thumb fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
26670	Treat hand dislocation		T	0043	1.6914	104.11		20.82
26675	Treat hand dislocation		T	0043	1.6914	104.11		20.82
26676	Pin hand dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
26685	Treat hand dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
26686	Treat hand dislocation	CH	T	0064	56.4195	3,472.68	825.22	694.54
26700	Treat knuckle dislocation		T	0043	1.6914	104.11		20.82
26705	Treat knuckle dislocation		T	0043	1.6914	104.11		20.82
26706	Pin knuckle dislocation		T	0043	1.6914	104.11		20.82
26715	Treat knuckle dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
26720	Treat finger fracture, each		T	0043	1.6914	104.11		20.82
26725	Treat finger fracture, each		T	0043	1.6914	104.11		20.82
26727	Treat finger fracture, each	CH	T	0062	25.6702	1,580.03	375.46	316.01
26735	Treat finger fracture, each	CH	T	0063	37.5680	2,312.35	549.49	462.47
26740	Treat finger fracture, each		T	0043	1.6914	104.11		20.82
26742	Treat finger fracture, each		T	0043	1.6914	104.11		20.82
26746	Treat finger fracture, each	CH	T	0063	37.5680	2,312.35	549.49	462.47
26750	Treat finger fracture, each		T	0043	1.6914	104.11		20.82
26755	Treat finger fracture, each		T	0043	1.6914	104.11		20.82
26756	Pin finger fracture, each	CH	T	0062	25.6702	1,580.03	375.46	316.01
26765	Treat finger fracture, each	CH	T	0063	37.5680	2,312.35	549.49	462.47
26770	Treat finger dislocation		T	0043	1.6914	104.11		20.82
26775	Treat finger dislocation		T	0045	14.5502	895.58	268.47	179.12
26776	Pin finger dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
26785	Treat finger dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
26820	Thumb fusion with graft		T	0054	25.8425	1,590.63		318.13
26841	Fusion of thumb		T	0054	25.8425	1,590.63		318.13
26842	Thumb fusion with graft		T	0054	25.8425	1,590.63		318.13
26843	Fusion of hand joint		T	0054	25.8425	1,590.63		318.13
26844	Fusion/graft of hand joint		T	0054	25.8425	1,590.63		318.13
26850	Fusion of knuckle		T	0054	25.8425	1,590.63		318.13
26852	Fusion of knuckle with graft		T	0054	25.8425	1,590.63		318.13
26860	Fusion of finger joint		T	0054	25.8425	1,590.63		318.13
26861	Fusion of finger jnt, add-on		T	0054	25.8425	1,590.63		318.13
26862	Fusion/graft of finger joint		T	0054	25.8425	1,590.63		318.13
26863	Fuse/graft added joint		T	0054	25.8425	1,590.63		318.13
26910	Amputate metacarpal bone		T	0054	25.8425	1,590.63		318.13
26951	Amputation of finger/thumb		T	0053	16.0343	986.93	253.49	197.39
26952	Amputation of finger/thumb		T	0053	16.0343	986.93	253.49	197.39
26989	Hand/finger surgery		T	0043	1.6914	104.11		20.82
26990	Drainage of pelvis lesion		T	0049	20.8214	1,281.58		256.32
26991	Drainage of pelvis bursa		T	0049	20.8214	1,281.58		256.32
27000	Incision of hip tendon		T	0049	20.8214	1,281.58		256.32
27001	Incision of hip tendon		T	0050	25.0600	1,542.47		308.49
27003	Incision of hip tendon		T	0050	25.0600	1,542.47		308.49
27033	Exploration of hip joint		T	0051	41.2543	2,539.24		507.85
27035	Denervation of hip joint	CH	T	0051	41.2543	2,539.24		507.85
27040	Biopsy of soft tissues		T	0020	6.5128	400.87	98.57	80.17
27041	Biopsy of soft tissues		T	0020	6.5128	400.87	98.57	80.17
27047	Remove hip/pelvis lesion		T	0022	19.9760	1,229.54	354.45	245.91
27048	Remove hip/pelvis lesion		T	0022	19.9760	1,229.54	354.45	245.91
27049	Remove tumor, hip/pelvis		T	0022	19.9760	1,229.54	354.45	245.91
27050	Biopsy of sacroiliac joint		T	0049	20.8214	1,281.58		256.32
27052	Biopsy of hip joint		T	0049	20.8214	1,281.58		256.32
27060	Removal of ischial bursa		T	0049	20.8214	1,281.58		256.32
27062	Remove femur lesion/bursa		T	0049	20.8214	1,281.58		256.32
27065	Removal of hip bone lesion		T	0049	20.8214	1,281.58		256.32
27066	Removal of hip bone lesion		T	0050	25.0600	1,542.47		308.49
27067	Remove/graft hip bone lesion		T	0050	25.0600	1,542.47		308.49
27080	Removal of tail bone		T	0050	25.0600	1,542.47		308.49
27086	Remove hip foreign body		T	0020	6.5128	400.87	98.57	80.17
27087	Remove hip foreign body		T	0049	20.8214	1,281.58		256.32
27093	Injection for hip x-ray		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27095	Injection for hip x-ray		N					
27097	Revision of hip tendon		T	0050	25.0600	1,542.47		308.49
27098	Transfer tendon to pelvis		T	0050	25.0600	1,542.47		308.49
27100	Transfer of abdominal muscle		T	0051	41.2543	2,539.24		507.85
27105	Transfer of spinal muscle		T	0051	41.2543	2,539.24		507.85
27110	Transfer of iliopsoas muscle		T	0051	41.2543	2,539.24		507.85
27111	Transfer of iliopsoas muscle		T	0051	41.2543	2,539.24		507.85
27193	Treat pelvic ring fracture		T	0043	1.6914	104.11		20.82
27194	Treat pelvic ring fracture		T	0045	14.5502	895.58	268.47	179.12
27200	Treat tail bone fracture		T	0043	1.6914	104.11		20.82
27202	Treat tail bone fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
27216	Treat pelvic ring fracture		T	0050	25.0600	1,542.47		308.49
27220	Treat hip socket fracture		T	0043	1.6914	104.11		20.82
27230	Treat thigh fracture		T	0043	1.6914	104.11		20.82
27235	Treat thigh fracture		T	0050	25.0600	1,542.47		308.49
27238	Treat thigh fracture		T	0043	1.6914	104.11		20.82
27246	Treat thigh fracture		T	0043	1.6914	104.11		20.82
27250	Treat hip dislocation		T	0043	1.6914	104.11		20.82
27252	Treat hip dislocation		T	0045	14.5502	895.58	268.47	179.12
27256	Treat hip dislocation		T	0043	1.6914	104.11		20.82
27257	Treat hip dislocation		T	0045	14.5502	895.58	268.47	179.12
27265	Treat hip dislocation		T	0043	1.6914	104.11		20.82
27266	Treat hip dislocation		T	0045	14.5502	895.58	268.47	179.12
27275	Manipulation of hip joint		T	0045	14.5502	895.58	268.47	179.12
27299	Pelvis/hip joint surgery		T	0043	1.6914	104.11		20.82
27301	Drain thigh/knee lesion		T	0008	17.4686	1,075.21		215.04
27305	Incise thigh tendon&fascia		T	0049	20.8214	1,281.58		256.32
27306	Incision of thigh tendon		T	0049	20.8214	1,281.58		256.32
27307	Incision of thigh tendons		T	0049	20.8214	1,281.58		256.32
27310	Exploration of knee joint		T	0050	25.0600	1,542.47		308.49
27315	Partial removal, thigh nerve		T	0220	17.7609	1,093.20		218.64
27320	Partial removal, thigh nerve		T	0220	17.7609	1,093.20		218.64
27323	Biopsy, thigh soft tissues	CH	T	0020	6.5128	400.87	98.57	80.17
27324	Biopsy, thigh soft tissues		T	0022	19.9760	1,229.54	354.45	245.91
27327	Removal of thigh lesion		T	0022	19.9760	1,229.54	354.45	245.91
27328	Removal of thigh lesion		T	0022	19.9760	1,229.54	354.45	245.91
27329	Remove tumor, thigh/knee		T	0022	19.9760	1,229.54	354.45	245.91
27330	Biopsy, knee joint lining		T	0050	25.0600	1,542.47		308.49
27331	Explore/treat knee joint		T	0050	25.0600	1,542.47		308.49
27332	Removal of knee cartilage		T	0050	25.0600	1,542.47		308.49
27333	Removal of knee cartilage		T	0050	25.0600	1,542.47		308.49
27334	Remove knee joint lining		T	0050	25.0600	1,542.47		308.49
27335	Remove knee joint lining		T	0050	25.0600	1,542.47		308.49
27340	Removal of kneecap bursa		T	0049	20.8214	1,281.58		256.32
27345	Removal of knee cyst		T	0049	20.8214	1,281.58		256.32
27347	Remove knee cyst		T	0049	20.8214	1,281.58		256.32
27350	Removal of kneecap		T	0050	25.0600	1,542.47		308.49
27355	Remove femur lesion		T	0050	25.0600	1,542.47		308.49
27356	Remove femur lesion/graft		T	0050	25.0600	1,542.47		308.49
27357	Remove femur lesion/graft		T	0050	25.0600	1,542.47		308.49
27358	Remove femur lesion/fixation		T	0050	25.0600	1,542.47		308.49
27360	Partial removal, leg bone(s)		T	0050	25.0600	1,542.47		308.49
27370	Injection for knee x-ray		N					
27372	Removal of foreign body		T	0022	19.9760	1,229.54	354.45	245.91
27380	Repair of kneecap tendon		T	0049	20.8214	1,281.58		256.32
27381	Repair/graft kneecap tendon		T	0049	20.8214	1,281.58		256.32
27385	Repair of thigh muscle		T	0049	20.8214	1,281.58		256.32
27386	Repair/graft of thigh muscle		T	0049	20.8214	1,281.58		256.32
27390	Incision of thigh tendon		T	0049	20.8214	1,281.58		256.32
27391	Incision of thigh tendons		T	0049	20.8214	1,281.58		256.32
27392	Incision of thigh tendons		T	0049	20.8214	1,281.58		256.32
27393	Lengthening of thigh tendon		T	0050	25.0600	1,542.47		308.49
27394	Lengthening of thigh tendons		T	0050	25.0600	1,542.47		308.49
27395	Lengthening of thigh tendons		T	0051	41.2543	2,539.24		507.85
27396	Transplant of thigh tendon		T	0050	25.0600	1,542.47		308.49
27397	Transplants of thigh tendons		T	0051	41.2543	2,539.24		507.85
27400	Revise thigh muscles/tendons		T	0051	41.2543	2,539.24		507.85
27403	Repair of knee cartilage		T	0050	25.0600	1,542.47		308.49
27405	Repair of knee ligament		T	0051	41.2543	2,539.24		507.85
27407	Repair of knee ligament	CH	T	0052	65.8846	4,055.26		811.05

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27409	Repair of knee ligaments		T	0051	41.2543	2,539.24		507.85
27412	Autochondrocyte implant knee		T	0042	45.0637	2,773.72	804.74	554.74
27415	Osteochondral knee allograft		T	0042	45.0637	2,773.72	804.74	554.74
27418	Repair degenerated kneecap		T	0051	41.2543	2,539.24		507.85
27420	Revision of unstable kneecap		T	0051	41.2543	2,539.24		507.85
27422	Revision of unstable kneecap		T	0051	41.2543	2,539.24		507.85
27424	Revision/removal of kneecap		T	0051	41.2543	2,539.24		507.85
27425	Lat retinacular release open		T	0050	25.0600	1,542.47		308.49
27427	Reconstruction, knee	CH	T	0051	41.2543	2,539.24		507.85
27428	Reconstruction, knee		T	0052	65.8846	4,055.26		811.05
27429	Reconstruction, knee		T	0052	65.8846	4,055.26		811.05
27430	Revision of thigh muscles		T	0051	41.2543	2,539.24		507.85
27435	Incision of knee joint		T	0051	41.2543	2,539.24		507.85
27437	Revise kneecap		T	0047	32.7543	2,016.06	537.03	403.21
27438	Revise kneecap with implant		T	0048	47.1644	2,903.02		580.60
27440	Revision of knee joint		T	0047	32.7543	2,016.06	537.03	403.21
27441	Revision of knee joint		T	0047	32.7543	2,016.06	537.03	403.21
27442	Revision of knee joint		T	0047	32.7543	2,016.06	537.03	403.21
27443	Revision of knee joint		T	0047	32.7543	2,016.06	537.03	403.21
27446	Revision of knee joint		T	0681	173.0706	10,652.67		2,130.53
27475	Surgery to stop leg growth		T	0050	25.0600	1,542.47		308.49
27496	Decompression of thigh/knee		T	0049	20.8214	1,281.58		256.32
27497	Decompression of thigh/knee		T	0049	20.8214	1,281.58		256.32
27498	Decompression of thigh/knee		T	0049	20.8214	1,281.58		256.32
27499	Decompression of thigh/knee		T	0049	20.8214	1,281.58		256.32
27500	Treatment of thigh fracture		T	0043	1.6914	104.11		20.82
27501	Treatment of thigh fracture		T	0043	1.6914	104.11		20.82
27502	Treatment of thigh fracture		T	0043	1.6914	104.11		20.82
27503	Treatment of thigh fracture		T	0043	1.6914	104.11		20.82
27508	Treatment of thigh fracture		T	0043	1.6914	104.11		20.82
27509	Treatment of thigh fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
27510	Treatment of thigh fracture		T	0043	1.6914	104.11		20.82
27516	Treat thigh fx growth plate		T	0043	1.6914	104.11		20.82
27517	Treat thigh fx growth plate		T	0043	1.6914	104.11		20.82
27520	Treat kneecap fracture		T	0043	1.6914	104.11		20.82
27524	Treat kneecap fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
27530	Treat knee fracture		T	0043	1.6914	104.11		20.82
27532	Treat knee fracture		T	0043	1.6914	104.11		20.82
27538	Treat knee fracture(s)		T	0043	1.6914	104.11		20.82
27550	Treat knee dislocation		T	0043	1.6914	104.11		20.82
27552	Treat knee dislocation		T	0045	14.5502	895.58	268.47	179.12
27560	Treat kneecap dislocation		T	0043	1.6914	104.11		20.82
27562	Treat kneecap dislocation		T	0045	14.5502	895.58	268.47	179.12
27566	Treat kneecap dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
27570	Fixation of knee joint		T	0045	14.5502	895.58	268.47	179.12
27594	Amputation follow-up surgery		T	0049	20.8214	1,281.58		256.32
27599	Leg surgery procedure		T	0043	1.6914	104.11		20.82
27600	Decompression of lower leg		T	0049	20.8214	1,281.58		256.32
27601	Decompression of lower leg		T	0049	20.8214	1,281.58		256.32
27602	Decompression of lower leg		T	0049	20.8214	1,281.58		256.32
27603	Drain lower leg lesion		T	0008	17.4686	1,075.21		215.04
27604	Drain lower leg bursa		T	0049	20.8214	1,281.58		256.32
27605	Incision of achilles tendon		T	0055	20.2255	1,244.90	355.34	248.98
27606	Incision of achilles tendon		T	0049	20.8214	1,281.58		256.32
27607	Treat lower leg bone lesion		T	0049	20.8214	1,281.58		256.32
27610	Explore/treat ankle joint		T	0050	25.0600	1,542.47		308.49
27612	Exploration of ankle joint		T	0050	25.0600	1,542.47		308.49
27613	Biopsy lower leg soft tissue		T	0020	6.5128	400.87	98.57	80.17
27614	Biopsy lower leg soft tissue		T	0022	19.9760	1,229.54	354.45	245.91
27615	Remove tumor, lower leg	CH	T	0050	25.0600	1,542.47		308.49
27618	Remove lower leg lesion		T	0021	14.9563	920.58	219.48	184.12
27619	Remove lower leg lesion		T	0022	19.9760	1,229.54	354.45	245.91
27620	Explore/treat ankle joint		T	0050	25.0600	1,542.47		308.49
27625	Remove ankle joint lining		T	0050	25.0600	1,542.47		308.49
27626	Remove ankle joint lining		T	0050	25.0600	1,542.47		308.49
27630	Removal of tendon lesion		T	0049	20.8214	1,281.58		256.32
27635	Remove lower leg bone lesion		T	0050	25.0600	1,542.47		308.49
27637	Remove/graft leg bone lesion		T	0050	25.0600	1,542.47		308.49
27638	Remove/graft leg bone lesion		T	0050	25.0600	1,542.47		308.49
27640	Partial removal of tibia		T	0051	41.2543	2,539.24		507.85

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27641	Partial removal of fibula		T	0050	25.0600	1,542.47		308.49
27647	Extensive ankle/heel surgery		T	0051	41.2543	2,539.24		507.85
27648	Injection for ankle x-ray		N					
27650	Repair achilles tendon		T	0051	41.2543	2,539.24		507.85
27652	Repair/graft achilles tendon	CH	T	0052	65.8846	4,055.26		811.05
27654	Repair of achilles tendon		T	0051	41.2543	2,539.24		507.85
27656	Repair leg fascia defect		T	0049	20.8214	1,281.58		256.32
27658	Repair of leg tendon, each		T	0049	20.8214	1,281.58		256.32
27659	Repair of leg tendon, each		T	0049	20.8214	1,281.58		256.32
27664	Repair of leg tendon, each		T	0049	20.8214	1,281.58		256.32
27665	Repair of leg tendon, each		T	0050	25.0600	1,542.47		308.49
27675	Repair lower leg tendons		T	0049	20.8214	1,281.58		256.32
27676	Repair lower leg tendons		T	0050	25.0600	1,542.47		308.49
27680	Release of lower leg tendon		T	0050	25.0600	1,542.47		308.49
27681	Release of lower leg tendons		T	0050	25.0600	1,542.47		308.49
27685	Revision of lower leg tendon		T	0050	25.0600	1,542.47		308.49
27686	Revise lower leg tendons		T	0050	25.0600	1,542.47		308.49
27687	Revision of calf tendon		T	0050	25.0600	1,542.47		308.49
27690	Revise lower leg tendon		T	0051	41.2543	2,539.24		507.85
27691	Revise lower leg tendon		T	0051	41.2543	2,539.24		507.85
27692	Revise additional leg tendon		T	0051	41.2543	2,539.24		507.85
27695	Repair of ankle ligament		T	0050	25.0600	1,542.47		308.49
27696	Repair of ankle ligaments		T	0050	25.0600	1,542.47		308.49
27698	Repair of ankle ligament		T	0050	25.0600	1,542.47		308.49
27700	Revision of ankle joint		T	0047	32.7543	2,016.06	537.03	403.21
27704	Removal of ankle implant		T	0049	20.8214	1,281.58		256.32
27705	Incision of tibia		T	0051	41.2543	2,539.24		507.85
27707	Incision of fibula		T	0049	20.8214	1,281.58		256.32
27709	Incision of tibia&fibula		T	0050	25.0600	1,542.47		308.49
27730	Repair of tibia epiphysis		T	0050	25.0600	1,542.47		308.49
27732	Repair of fibula epiphysis		T	0050	25.0600	1,542.47		308.49
27734	Repair lower leg epiphyses		T	0050	25.0600	1,542.47		308.49
27740	Repair of leg epiphyses		T	0050	25.0600	1,542.47		308.49
27742	Repair of leg epiphyses		T	0051	41.2543	2,539.24		507.85
27745	Reinforce tibia	CH	T	0052	65.8846	4,055.26		811.05
27750	Treatment of tibia fracture		T	0043	1.6914	104.11		20.82
27752	Treatment of tibia fracture		T	0043	1.6914	104.11		20.82
27756	Treatment of tibia fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
27758	Treatment of tibia fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
27759	Treatment of tibia fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
27760	Treatment of ankle fracture		T	0043	1.6914	104.11		20.82
27762	Treatment of ankle fracture		T	0043	1.6914	104.11		20.82
27766	Treatment of ankle fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
27780	Treatment of fibula fracture		T	0043	1.6914	104.11		20.82
27781	Treatment of fibula fracture		T	0043	1.6914	104.11		20.82
27784	Treatment of fibula fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
27786	Treatment of ankle fracture		T	0043	1.6914	104.11		20.82
27788	Treatment of ankle fracture		T	0043	1.6914	104.11		20.82
27792	Treatment of ankle fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
27808	Treatment of ankle fracture		T	0043	1.6914	104.11		20.82
27810	Treatment of ankle fracture		T	0043	1.6914	104.11		20.82
27814	Treatment of ankle fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
27816	Treatment of ankle fracture		T	0043	1.6914	104.11		20.82
27818	Treatment of ankle fracture		T	0043	1.6914	104.11		20.82
27822	Treatment of ankle fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
27823	Treatment of ankle fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
27824	Treat lower leg fracture		T	0043	1.6914	104.11		20.82
27825	Treat lower leg fracture		T	0043	1.6914	104.11		20.82
27826	Treat lower leg fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
27827	Treat lower leg fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
27828	Treat lower leg fracture	CH	T	0064	56.4195	3,472.68	825.22	694.54
27829	Treat lower leg joint	CH	T	0063	37.5680	2,312.35	549.49	462.47
27830	Treat lower leg dislocation		T	0043	1.6914	104.11		20.82
27831	Treat lower leg dislocation		T	0043	1.6914	104.11		20.82
27832	Treat lower leg dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
27840	Treat ankle dislocation		T	0043	1.6914	104.11		20.82
27842	Treat ankle dislocation		T	0045	14.5502	895.58	268.47	179.12
27846	Treat ankle dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
27848	Treat ankle dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
27860	Fixation of ankle joint		T	0045	14.5502	895.58	268.47	179.12

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27870	Fusion of ankle joint, open	CH	T	0052	65.8846	4,055.26		811.05
27871	Fusion of tibiofibular joint	CH	T	0052	65.8846	4,055.26		811.05
27884	Amputation follow-up surgery		T	0049	20.8214	1,281.58		256.32
27889	Amputation of foot at ankle		T	0050	25.0600	1,542.47		308.49
27892	Decompression of leg		T	0049	20.8214	1,281.58		256.32
27893	Decompression of leg		T	0049	20.8214	1,281.58		256.32
27894	Decompression of leg		T	0049	20.8214	1,281.58		256.32
27899	Leg/ankle surgery procedure		T	0043	1.6914	104.11		20.82
28001	Drainage of bursa of foot		T	0007	10.9184	672.04		134.41
28002	Treatment of foot infection		T	0049	20.8214	1,281.58		256.32
28003	Treatment of foot infection		T	0049	20.8214	1,281.58		256.32
28005	Treat foot bone lesion		T	0055	20.2255	1,244.90	355.34	248.98
28008	Incision of foot fascia		T	0055	20.2255	1,244.90	355.34	248.98
28010	Incision of toe tendon		T	0055	20.2255	1,244.90	355.34	248.98
28011	Incision of toe tendons		T	0055	20.2255	1,244.90	355.34	248.98
28020	Exploration of foot joint		T	0055	20.2255	1,244.90	355.34	248.98
28022	Exploration of foot joint		T	0055	20.2255	1,244.90	355.34	248.98
28024	Exploration of toe joint		T	0055	20.2255	1,244.90	355.34	248.98
28030	Removal of foot nerve		T	0220	17.7609	1,093.20		218.64
28035	Decompression of tibia nerve		T	0220	17.7609	1,093.20		218.64
28043	Excision of foot lesion	CH	T	0022	19.9760	1,229.54	354.45	245.91
28045	Excision of foot lesion		T	0055	20.2255	1,244.90	355.34	248.98
28046	Resection of tumor, foot		T	0055	20.2255	1,244.90	355.34	248.98
28050	Biopsy of foot joint lining		T	0055	20.2255	1,244.90	355.34	248.98
28052	Biopsy of foot joint lining		T	0055	20.2255	1,244.90	355.34	248.98
28054	Biopsy of toe joint lining		T	0055	20.2255	1,244.90	355.34	248.98
28060	Partial removal, foot fascia		T	0055	20.2255	1,244.90	355.34	248.98
28062	Removal of foot fascia		T	0055	20.2255	1,244.90	355.34	248.98
28070	Removal of foot joint lining		T	0055	20.2255	1,244.90	355.34	248.98
28072	Removal of foot joint lining		T	0055	20.2255	1,244.90	355.34	248.98
28080	Removal of foot lesion		T	0055	20.2255	1,244.90	355.34	248.98
28086	Excise foot tendon sheath		T	0055	20.2255	1,244.90	355.34	248.98
28088	Excise foot tendon sheath		T	0055	20.2255	1,244.90	355.34	248.98
28090	Removal of foot lesion		T	0055	20.2255	1,244.90	355.34	248.98
28092	Removal of toe lesions		T	0055	20.2255	1,244.90	355.34	248.98
28100	Removal of ankle/heel lesion		T	0055	20.2255	1,244.90	355.34	248.98
28102	Remove/graft foot lesion		T	0056	41.2239	2,537.37		507.47
28103	Remove/graft foot lesion		T	0056	41.2239	2,537.37		507.47
28104	Removal of foot lesion		T	0055	20.2255	1,244.90	355.34	248.98
28106	Remove/graft foot lesion		T	0056	41.2239	2,537.37		507.47
28107	Remove/graft foot lesion		T	0056	41.2239	2,537.37		507.47
28108	Removal of toe lesions		T	0055	20.2255	1,244.90	355.34	248.98
28110	Part removal of metatarsal		T	0055	20.2255	1,244.90	355.34	248.98
28111	Part removal of metatarsal		T	0055	20.2255	1,244.90	355.34	248.98
28112	Part removal of metatarsal		T	0055	20.2255	1,244.90	355.34	248.98
28113	Part removal of metatarsal		T	0055	20.2255	1,244.90	355.34	248.98
28114	Removal of metatarsal heads		T	0055	20.2255	1,244.90	355.34	248.98
28116	Revision of foot		T	0055	20.2255	1,244.90	355.34	248.98
28118	Removal of heel bone		T	0055	20.2255	1,244.90	355.34	248.98
28119	Removal of heel spur		T	0055	20.2255	1,244.90	355.34	248.98
28120	Part removal of ankle/heel		T	0055	20.2255	1,244.90	355.34	248.98
28122	Partial removal of foot bone		T	0055	20.2255	1,244.90	355.34	248.98
28124	Partial removal of toe		T	0055	20.2255	1,244.90	355.34	248.98
28126	Partial removal of toe		T	0055	20.2255	1,244.90	355.34	248.98
28130	Removal of ankle bone		T	0055	20.2255	1,244.90	355.34	248.98
28140	Removal of metatarsal		T	0055	20.2255	1,244.90	355.34	248.98
28150	Removal of toe		T	0055	20.2255	1,244.90	355.34	248.98
28153	Partial removal of toe		T	0055	20.2255	1,244.90	355.34	248.98
28160	Partial removal of toe		T	0055	20.2255	1,244.90	355.34	248.98
28171	Extensive foot surgery		T	0055	20.2255	1,244.90	355.34	248.98
28173	Extensive foot surgery		T	0055	20.2255	1,244.90	355.34	248.98
28175	Extensive foot surgery		T	0055	20.2255	1,244.90	355.34	248.98
28190	Removal of foot foreign body		T	0019	4.0123	246.96	71.87	49.39
28192	Removal of foot foreign body		T	0021	14.9563	920.58	219.48	184.12
28193	Removal of foot foreign body		T	0020	6.5128	400.87	98.57	80.17
28200	Repair of foot tendon		T	0055	20.2255	1,244.90	355.34	248.98
28202	Repair/graft of foot tendon		T	0055	20.2255	1,244.90	355.34	248.98
28208	Repair of foot tendon		T	0055	20.2255	1,244.90	355.34	248.98
28210	Repair/graft of foot tendon		T	0056	41.2239	2,537.37		507.47
28220	Release of foot tendon		T	0055	20.2255	1,244.90	355.34	248.98

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28222	Release of foot tendons		T	0055	20.2255	1,244.90	355.34	248.98
28225	Release of foot tendon		T	0055	20.2255	1,244.90	355.34	248.98
28226	Release of foot tendons		T	0055	20.2255	1,244.90	355.34	248.98
28230	Incision of foot tendon(s)		T	0055	20.2255	1,244.90	355.34	248.98
28232	Incision of toe tendon		T	0055	20.2255	1,244.90	355.34	248.98
28234	Incision of foot tendon		T	0055	20.2255	1,244.90	355.34	248.98
28238	Revision of foot tendon		T	0056	41.2239	2,537.37		507.47
28240	Release of big toe		T	0055	20.2255	1,244.90	355.34	248.98
28250	Revision of foot fascia		T	0055	20.2255	1,244.90	355.34	248.98
28260	Release of midfoot joint		T	0055	20.2255	1,244.90	355.34	248.98
28261	Revision of foot tendon		T	0055	20.2255	1,244.90	355.34	248.98
28262	Revision of foot and ankle		T	0055	20.2255	1,244.90	355.34	248.98
28264	Release of midfoot joint		T	0056	41.2239	2,537.37		507.47
28270	Release of foot contracture		T	0055	20.2255	1,244.90	355.34	248.98
28272	Release of toe joint, each		T	0055	20.2255	1,244.90	355.34	248.98
28280	Fusion of toes		T	0055	20.2255	1,244.90	355.34	248.98
28285	Repair of hammertoe		T	0055	20.2255	1,244.90	355.34	248.98
28286	Repair of hammertoe		T	0055	20.2255	1,244.90	355.34	248.98
28288	Partial removal of foot bone		T	0055	20.2255	1,244.90	355.34	248.98
28289	Repair hallux rigidus		T	0055	20.2255	1,244.90	355.34	248.98
28290	Correction of bunion		T	0057	28.0970	1,729.40	475.91	345.88
28292	Correction of bunion		T	0057	28.0970	1,729.40	475.91	345.88
28293	Correction of bunion		T	0057	28.0970	1,729.40	475.91	345.88
28294	Correction of bunion		T	0057	28.0970	1,729.40	475.91	345.88
28296	Correction of bunion		T	0057	28.0970	1,729.40	475.91	345.88
28297	Correction of bunion		T	0057	28.0970	1,729.40	475.91	345.88
28298	Correction of bunion		T	0057	28.0970	1,729.40	475.91	345.88
28299	Correction of bunion		T	0057	28.0970	1,729.40	475.91	345.88
28300	Incision of heel bone		T	0056	41.2239	2,537.37		507.47
28302	Incision of ankle bone		T	0055	20.2255	1,244.90	355.34	248.98
28304	Incision of midfoot bones		T	0056	41.2239	2,537.37		507.47
28305	Incise/graft midfoot bones		T	0056	41.2239	2,537.37		507.47
28306	Incision of metatarsal		T	0055	20.2255	1,244.90	355.34	248.98
28307	Incision of metatarsal		T	0055	20.2255	1,244.90	355.34	248.98
28308	Incision of metatarsal		T	0055	20.2255	1,244.90	355.34	248.98
28309	Incision of metatarsals		T	0056	41.2239	2,537.37		507.47
28310	Revision of big toe		T	0055	20.2255	1,244.90	355.34	248.98
28312	Revision of toe		T	0055	20.2255	1,244.90	355.34	248.98
28313	Repair deformity of toe		T	0055	20.2255	1,244.90	355.34	248.98
28315	Removal of sesamoid bone		T	0055	20.2255	1,244.90	355.34	248.98
28320	Repair of foot bones		T	0056	41.2239	2,537.37		507.47
28322	Repair of metatarsals		T	0056	41.2239	2,537.37		507.47
28340	Resect enlarged toe tissue		T	0055	20.2255	1,244.90	355.34	248.98
28341	Resect enlarged toe		T	0055	20.2255	1,244.90	355.34	248.98
28344	Repair extra toe(s)		T	0055	20.2255	1,244.90	355.34	248.98
28345	Repair webbed toe(s)		T	0055	20.2255	1,244.90	355.34	248.98
28360	Reconstruct cleft foot		T	0056	41.2239	2,537.37		507.47
28400	Treatment of heel fracture		T	0043	1.6914	104.11		20.82
28405	Treatment of heel fracture		T	0043	1.6914	104.11		20.82
28406	Treatment of heel fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
28415	Treat heel fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
28420	Treat/graft heel fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
28430	Treatment of ankle fracture		T	0043	1.6914	104.11		20.82
28435	Treatment of ankle fracture		T	0043	1.6914	104.11		20.82
28436	Treatment of ankle fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
28445	Treat ankle fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
28450	Treat midfoot fracture, each		T	0043	1.6914	104.11		20.82
28455	Treat midfoot fracture, each		T	0043	1.6914	104.11		20.82
28456	Treat midfoot fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
28465	Treat midfoot fracture, each	CH	T	0063	37.5680	2,312.35	549.49	462.47
28470	Treat metatarsal fracture		T	0043	1.6914	104.11		20.82
28475	Treat metatarsal fracture		T	0043	1.6914	104.11		20.82
28476	Treat metatarsal fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
28485	Treat metatarsal fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
28490	Treat big toe fracture		T	0043	1.6914	104.11		20.82
28495	Treat big toe fracture		T	0043	1.6914	104.11		20.82
28496	Treat big toe fracture	CH	T	0062	25.6702	1,580.03	375.46	316.01
28505	Treat big toe fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
28510	Treatment of toe fracture		T	0043	1.6914	104.11		20.82
28515	Treatment of toe fracture		T	0043	1.6914	104.11		20.82

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28525	Treat toe fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
28530	Treat sesamoid bone fracture		T	0043	1.6914	104.11		20.82
28531	Treat sesamoid bone fracture	CH	T	0063	37.5680	2,312.35	549.49	462.47
28540	Treat foot dislocation		T	0043	1.6914	104.11		20.82
28545	Treat foot dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
28546	Treat foot dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
28555	Repair foot dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
28570	Treat foot dislocation		T	0043	1.6914	104.11		20.82
28575	Treat foot dislocation		T	0043	1.6914	104.11		20.82
28576	Treat foot dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
28585	Repair foot dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
28600	Treat foot dislocation		T	0043	1.6914	104.11		20.82
28605	Treat foot dislocation		T	0043	1.6914	104.11		20.82
28606	Treat foot dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
28615	Repair foot dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
28630	Treat toe dislocation		T	0043	1.6914	104.11		20.82
28635	Treat toe dislocation		T	0045	14.5502	895.58	268.47	179.12
28636	Treat toe dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
28645	Repair toe dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
28660	Treat toe dislocation		T	0043	1.6914	104.11		20.82
28665	Treat toe dislocation		T	0045	14.5502	895.58	268.47	179.12
28666	Treat toe dislocation	CH	T	0062	25.6702	1,580.03	375.46	316.01
28675	Repair of toe dislocation	CH	T	0063	37.5680	2,312.35	549.49	462.47
28705	Fusion of foot bones		T	0056	41.2239	2,537.37		507.47
28715	Fusion of foot bones		T	0056	41.2239	2,537.37		507.47
28725	Fusion of foot bones		T	0056	41.2239	2,537.37		507.47
28730	Fusion of foot bones		T	0056	41.2239	2,537.37		507.47
28735	Fusion of foot bones		T	0056	41.2239	2,537.37		507.47
28737	Revision of foot bones		T	0056	41.2239	2,537.37		507.47
28740	Fusion of foot bones		T	0056	41.2239	2,537.37		507.47
28750	Fusion of big toe joint		T	0056	41.2239	2,537.37		507.47
28755	Fusion of big toe joint		T	0055	20.2255	1,244.90	355.34	248.98
28760	Fusion of big toe joint		T	0056	41.2239	2,537.37		507.47
28810	Amputation toe&metatarsal		T	0055	20.2255	1,244.90	355.34	248.98
28820	Amputation of toe		T	0055	20.2255	1,244.90	355.34	248.98
28825	Partial amputation of toe		T	0055	20.2255	1,244.90	355.34	248.98
28890	High energy eswt, plantar f	CH	T	0050	25.0600	1,542.47		308.49
28899	Foot/toes surgery procedure		T	0043	1.6914	104.11		20.82
29000	Application of body cast		S	0058	1.0504	64.65		12.93
29010	Application of body cast		S	0426	2.2728	139.89		27.98
29015	Application of body cast		S	0426	2.2728	139.89		27.98
29020	Application of body cast		S	0058	1.0504	64.65		12.93
29025	Application of body cast		S	0058	1.0504	64.65		12.93
29035	Application of body cast		S	0426	2.2728	139.89		27.98
29040	Application of body cast		S	0058	1.0504	64.65		12.93
29044	Application of body cast		S	0426	2.2728	139.89		27.98
29046	Application of body cast		S	0426	2.2728	139.89		27.98
29049	Application of figure eight		S	0058	1.0504	64.65		12.93
29055	Application of shoulder cast		S	0426	2.2728	139.89		27.98
29058	Application of shoulder cast		S	0058	1.0504	64.65		12.93
29065	Application of long arm cast		S	0426	2.2728	139.89		27.98
29075	Application of forearm cast		S	0426	2.2728	139.89		27.98
29085	Apply hand/wrist cast		S	0058	1.0504	64.65		12.93
29086	Apply finger cast		S	0058	1.0504	64.65		12.93
29105	Apply long arm splint		S	0058	1.0504	64.65		12.93
29125	Apply forearm splint		S	0058	1.0504	64.65		12.93
29126	Apply forearm splint		S	0058	1.0504	64.65		12.93
29130	Application of finger splint		S	0058	1.0504	64.65		12.93
29131	Application of finger splint		S	0058	1.0504	64.65		12.93
29200	Strapping of chest		S	0058	1.0504	64.65		12.93
29220	Strapping of low back		S	0058	1.0504	64.65		12.93
29240	Strapping of shoulder		S	0058	1.0504	64.65		12.93
29260	Strapping of elbow or wrist		S	0058	1.0504	64.65		12.93
29280	Strapping of hand or finger		S	0058	1.0504	64.65		12.93
29305	Application of hip cast		S	0426	2.2728	139.89		27.98
29325	Application of hip casts		S	0426	2.2728	139.89		27.98
29345	Application of long leg cast		S	0426	2.2728	139.89		27.98
29355	Application of long leg cast		S	0426	2.2728	139.89		27.98
29358	Apply long leg cast brace		S	0426	2.2728	139.89		27.98
29365	Application of long leg cast		S	0426	2.2728	139.89		27.98

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29405	Apply short leg cast		S	0426	2.2728	139.89		27.98
29425	Apply short leg cast		S	0426	2.2728	139.89		27.98
29435	Apply short leg cast		S	0426	2.2728	139.89		27.98
29440	Addition of walker to cast		S	0058	1.0504	64.65		12.93
29445	Apply rigid leg cast		S	0426	2.2728	139.89		27.98
29450	Application of leg cast		S	0058	1.0504	64.65		12.93
29505	Application, long leg splint		S	0058	1.0504	64.65		12.93
29515	Application lower leg splint		S	0058	1.0504	64.65		12.93
29520	Strapping of hip		S	0058	1.0504	64.65		12.93
29530	Strapping of knee		S	0058	1.0504	64.65		12.93
29540	Strapping of ankle and/or ft		S	0058	1.0504	64.65		12.93
29550	Strapping of toes		S	0058	1.0504	64.65		12.93
29580	Application of paste boot		S	0058	1.0504	64.65		12.93
29590	Application of foot splint		S	0058	1.0504	64.65		12.93
29700	Removal/revision of cast		S	0058	1.0504	64.65		12.93
29705	Removal/revision of cast		S	0058	1.0504	64.65		12.93
29710	Removal/revision of cast		S	0426	2.2728	139.89		27.98
29715	Removal/revision of cast		S	0058	1.0504	64.65		12.93
29720	Repair of body cast		S	0058	1.0504	64.65		12.93
29730	Windowing of cast		S	0058	1.0504	64.65		12.93
29740	Wedging of cast		S	0058	1.0504	64.65		12.93
29750	Wedging of clubfoot cast		S	0058	1.0504	64.65		12.93
29799	Casting/strapping procedure		S	0058	1.0504	64.65		12.93
29800	Jaw arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29804	Jaw arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29805	Shoulder arthroscopy, dx		T	0041	28.6279	1,762.08		352.42
29806	Shoulder arthroscopy/surgery		T	0042	45.0637	2,773.72	804.74	554.74
29807	Shoulder arthroscopy/surgery		T	0042	45.0637	2,773.72	804.74	554.74
29819	Shoulder arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29820	Shoulder arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29821	Shoulder arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29822	Shoulder arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29823	Shoulder arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29824	Shoulder arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29825	Shoulder arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29826	Shoulder arthroscopy/surgery		T	0042	45.0637	2,773.72	804.74	554.74
29827	Arthroscop rotator cuff repr		T	0042	45.0637	2,773.72	804.74	554.74
29830	Elbow arthroscopy		T	0041	28.6279	1,762.08		352.42
29834	Elbow arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29835	Elbow arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29836	Elbow arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29837	Elbow arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29838	Elbow arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29840	Wrist arthroscopy		T	0041	28.6279	1,762.08		352.42
29843	Wrist arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29844	Wrist arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29845	Wrist arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29846	Wrist arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29847	Wrist arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29848	Wrist endoscopy/surgery		T	0041	28.6279	1,762.08		352.42
29850	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29851	Knee arthroscopy/surgery		T	0042	45.0637	2,773.72	804.74	554.74
29855	Tibial arthroscopy/surgery		T	0042	45.0637	2,773.72	804.74	554.74
29856	Tibial arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29860	Hip arthroscopy, dx		T	0041	28.6279	1,762.08		352.42
29861	Hip arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29862	Hip arthroscopy/surgery		T	0042	45.0637	2,773.72	804.74	554.74
29863	Hip arthroscopy/surgery		T	0042	45.0637	2,773.72	804.74	554.74
29866	Autgrft implnt, knee w/scope		T	0042	45.0637	2,773.72	804.74	554.74
29867	Allgrft implnt, knee w/scope		T	0042	45.0637	2,773.72	804.74	554.74
29868	Meniscal trnspl, knee w/scpe		T	0042	45.0637	2,773.72	804.74	554.74
29870	Knee arthroscopy, dx		T	0041	28.6279	1,762.08		352.42
29871	Knee arthroscopy/drainage		T	0041	28.6279	1,762.08		352.42
29873	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29874	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29875	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29876	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29877	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29879	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29880	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29881	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29882	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29883	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29884	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29885	Knee arthroscopy/surgery		T	0042	45.0637	2,773.72	804.74	554.74
29886	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29887	Knee arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29888	Knee arthroscopy/surgery		T	0042	45.0637	2,773.72	804.74	554.74
29889	Knee arthroscopy/surgery		T	0042	45.0637	2,773.72	804.74	554.74
29891	Ankle arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29892	Ankle arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29893	Scope, plantar fasciotomy		T	0055	20.2255	1,244.90	355.34	248.98
29894	Ankle arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29895	Ankle arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29897	Ankle arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29898	Ankle arthroscopy/surgery		T	0041	28.6279	1,762.08		352.42
29899	Ankle arthroscopy/surgery		T	0042	45.0637	2,773.72	804.74	554.74
29900	Mcp joint arthroscopy, dx		T	0053	16.0343	986.93	253.49	197.39
29901	Mcp joint arthroscopy, surg		T	0053	16.0343	986.93	253.49	197.39
29902	Mcp joint arthroscopy, surg		T	0053	16.0343	986.93	253.49	197.39
29999	Arthroscopy of joint		T	0252	7.7261	475.55	111.84	95.11
30110	Removal of nose polyp(s)		T	0253	16.4494	1,012.48	282.29	202.50
30115	Removal of nose polyp(s)		T	0253	16.4494	1,012.48	282.29	202.50
30117	Removal of intranasal lesion		T	0253	16.4494	1,012.48	282.29	202.50
30118	Removal of intranasal lesion		T	0254	23.1564	1,425.30	321.35	285.06
30120	Revision of nose		T	0253	16.4494	1,012.48	282.29	202.50
30124	Removal of nose lesion		T	0252	7.7261	475.55	111.84	95.11
30125	Removal of nose lesion		T	0256	37.7719	2,324.90		464.98
30130	Excise inferior turbinate		T	0253	16.4494	1,012.48	282.29	202.50
30140	Resect inferior turbinate		T	0254	23.1564	1,425.30	321.35	285.06
30150	Partial removal of nose		T	0256	37.7719	2,324.90		464.98
30160	Removal of nose		T	0256	37.7719	2,324.90		464.98
30200	Injection treatment of nose		T	0252	7.7261	475.55	111.84	95.11
30210	Nasal sinus therapy		T	0252	7.7261	475.55	111.84	95.11
30220	Insert nasal septal button		T	0252	7.7261	475.55	111.84	95.11
30300	Remove nasal foreign body		X	0340	0.6211	38.23		7.65
30310	Remove nasal foreign body		T	0253	16.4494	1,012.48	282.29	202.50
30320	Remove nasal foreign body		T	0253	16.4494	1,012.48	282.29	202.50
30400	Reconstruction of nose		T	0256	37.7719	2,324.90		464.98
30410	Reconstruction of nose		T	0256	37.7719	2,324.90		464.98
30420	Reconstruction of nose		T	0256	37.7719	2,324.90		464.98
30430	Revision of nose		T	0254	23.1564	1,425.30	321.35	285.06
30435	Revision of nose		T	0256	37.7719	2,324.90		464.98
30450	Revision of nose		T	0256	37.7719	2,324.90		464.98
30460	Revision of nose		T	0256	37.7719	2,324.90		464.98
30462	Revision of nose		T	0256	37.7719	2,324.90		464.98
30465	Repair nasal stenosis		T	0256	37.7719	2,324.90		464.98
30520	Repair of nasal septum		T	0254	23.1564	1,425.30	321.35	285.06
30540	Repair nasal defect		T	0256	37.7719	2,324.90		464.98
30545	Repair nasal defect		T	0256	37.7719	2,324.90		464.98
30560	Release of nasal adhesions		T	0251	2.3768	146.29		29.26
30580	Repair upper jaw fistula		T	0256	37.7719	2,324.90		464.98
30600	Repair mouth/nose fistula		T	0256	37.7719	2,324.90		464.98
30620	Intranasal reconstruction		T	0256	37.7719	2,324.90		464.98
30630	Repair nasal septum defect		T	0254	23.1564	1,425.30	321.35	285.06
30801	Ablate inf turbinate, superf		T	0252	7.7261	475.55	111.84	95.11
30802	Cauterization, inner nose		T	0252	7.7261	475.55	111.84	95.11
30901	Control of nosebleed		T	0250	1.2021	73.99	25.50	14.80
30903	Control of nosebleed		T	0250	1.2021	73.99	25.50	14.80
30905	Control of nosebleed		T	0250	1.2021	73.99	25.50	14.80
30906	Repeat control of nosebleed		T	0250	1.2021	73.99	25.50	14.80
30915	Ligation, nasal sinus artery	CH	T	0092	24.5817	1,513.03	306.56	302.61
30920	Ligation, upper jaw artery		T	0092	24.5817	1,513.03	306.56	302.61
30930	Ther fx, nasal inf turbinate		T	0253	16.4494	1,012.48	282.29	202.50
30999	Nasal surgery procedure		T	0251	2.3768	146.29		29.26
31000	Irrigation, maxillary sinus		T	0251	2.3768	146.29		29.26
31002	Irrigation, sphenoid sinus		T	0252	7.7261	475.55	111.84	95.11
31020	Exploration, maxillary sinus		T	0254	23.1564	1,425.30	321.35	285.06
31030	Exploration, maxillary sinus		T	0256	37.7719	2,324.90		464.98
31032	Explore sinus, remove polyps		T	0256	37.7719	2,324.90		464.98

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31040	Exploration behind upper jaw		T	0254	23.1564	1,425.30	321.35	285.06
31050	Exploration, sphenoid sinus		T	0256	37.7719	2,324.90		464.98
31051	Sphenoid sinus surgery		T	0256	37.7719	2,324.90		464.98
31070	Exploration of frontal sinus		T	0254	23.1564	1,425.30	321.35	285.06
31075	Exploration of frontal sinus		T	0256	37.7719	2,324.90		464.98
31080	Removal of frontal sinus		T	0256	37.7719	2,324.90		464.98
31081	Removal of frontal sinus		T	0256	37.7719	2,324.90		464.98
31084	Removal of frontal sinus		T	0256	37.7719	2,324.90		464.98
31085	Removal of frontal sinus		T	0256	37.7719	2,324.90		464.98
31086	Removal of frontal sinus		T	0256	37.7719	2,324.90		464.98
31087	Removal of frontal sinus		T	0256	37.7719	2,324.90		464.98
31090	Exploration of sinuses		T	0256	37.7719	2,324.90		464.98
31200	Removal of ethmoid sinus		T	0256	37.7719	2,324.90		464.98
31201	Removal of ethmoid sinus		T	0256	37.7719	2,324.90		464.98
31205	Removal of ethmoid sinus		T	0256	37.7719	2,324.90		464.98
31231	Nasal endoscopy, dx		T	0072	1.4038	86.41	21.27	17.28
31233	Nasal/sinus endoscopy, dx		T	0072	1.4038	86.41	21.27	17.28
31235	Nasal/sinus endoscopy, dx		T	0074	15.1300	931.27	295.70	186.25
31237	Nasal/sinus endoscopy, surg	CH	T	0074	15.1300	931.27	295.70	186.25
31238	Nasal/sinus endoscopy, surg		T	0074	15.1300	931.27	295.70	186.25
31239	Nasal/sinus endoscopy, surg		T	0075	21.8010	1,341.87	445.92	268.37
31240	Nasal/sinus endoscopy, surg		T	0074	15.1300	931.27	295.70	186.25
31254	Revision of ethmoid sinus		T	0075	21.8010	1,341.87	445.92	268.37
31255	Removal of ethmoid sinus		T	0075	21.8010	1,341.87	445.92	268.37
31256	Exploration maxillary sinus		T	0075	21.8010	1,341.87	445.92	268.37
31267	Endoscopy, maxillary sinus		T	0075	21.8010	1,341.87	445.92	268.37
31276	Sinus endoscopy, surgical		T	0075	21.8010	1,341.87	445.92	268.37
31287	Nasal/sinus endoscopy, surg		T	0075	21.8010	1,341.87	445.92	268.37
31288	Nasal/sinus endoscopy, surg		T	0075	21.8010	1,341.87	445.92	268.37
31292	Nasal/sinus endoscopy, surg		T	0075	21.8010	1,341.87	445.92	268.37
31293	Nasal/sinus endoscopy, surg		T	0075	21.8010	1,341.87	445.92	268.37
31294	Nasal/sinus endoscopy, surg		T	0075	21.8010	1,341.87	445.92	268.37
31299	Sinus surgery procedure		T	0251	2.3768	146.29		29.26
31300	Removal of larynx lesion		T	0254	23.1564	1,425.30	321.35	285.06
31320	Diagnostic incision, larynx		T	0256	37.7719	2,324.90		464.98
31400	Revision of larynx		T	0256	37.7719	2,324.90		464.98
31420	Removal of epiglottis		T	0256	37.7719	2,324.90		464.98
31500	Insert emergency airway		S	0094	2.4630	151.60	46.29	30.32
31502	Change of windpipe airway		T	0121	2.3431	144.22	43.80	28.84
31505	Diagnostic laryngoscopy		T	0071	0.7572	46.61	11.03	9.32
31510	Laryngoscopy with biopsy		T	0074	15.1300	931.27	295.70	186.25
31511	Remove foreign body, larynx		T	0072	1.4038	86.41	21.27	17.28
31512	Removal of larynx lesion		T	0074	15.1300	931.27	295.70	186.25
31513	Injection into vocal cord		T	0072	1.4038	86.41	21.27	17.28
31515	Laryngoscopy for aspiration		T	0074	15.1300	931.27	295.70	186.25
31520	Dx laryngoscopy, newborn		T	0072	1.4038	86.41	21.27	17.28
31525	Dx laryngoscopy excl nb		T	0074	15.1300	931.27	295.70	186.25
31526	Dx laryngoscopy w/oper scope		T	0075	21.8010	1,341.87	445.92	268.37
31527	Laryngoscopy for treatment		T	0075	21.8010	1,341.87	445.92	268.37
31528	Laryngoscopy and dilation		T	0074	15.1300	931.27	295.70	186.25
31529	Laryngoscopy and dilation		T	0074	15.1300	931.27	295.70	186.25
31530	Laryngoscopy w/fb removal		T	0075	21.8010	1,341.87	445.92	268.37
31531	Laryngoscopy w/fb&op scope		T	0075	21.8010	1,341.87	445.92	268.37
31535	Laryngoscopy w/biopsy		T	0075	21.8010	1,341.87	445.92	268.37
31536	Laryngoscopy w/bx&op scope		T	0075	21.8010	1,341.87	445.92	268.37
31540	Laryngoscopy w/exc of tumor		T	0075	21.8010	1,341.87	445.92	268.37
31541	Larynscop w/tumr exc + scope		T	0075	21.8010	1,341.87	445.92	268.37
31545	Remove vc lesion w/scope		T	0075	21.8010	1,341.87	445.92	268.37
31546	Remove vc lesion scope/graft		T	0075	21.8010	1,341.87	445.92	268.37
31560	Laryngoscop w/arytenoidectom		T	0075	21.8010	1,341.87	445.92	268.37
31561	Larynscop, remve cart + scop		T	0075	21.8010	1,341.87	445.92	268.37
31570	Laryngoscope w/vc inj		T	0074	15.1300	931.27	295.70	186.25
31571	Laryngoscop w/vc inj + scope		T	0075	21.8010	1,341.87	445.92	268.37
31575	Diagnostic laryngoscopy		T	0072	1.4038	86.41	21.27	17.28
31576	Laryngoscopy with biopsy		T	0075	21.8010	1,341.87	445.92	268.37
31577	Remove foreign body, larynx		T	0073	3.8737	238.43	69.72	47.69
31578	Removal of larynx lesion		T	0075	21.8010	1,341.87	445.92	268.37
31579	Diagnostic laryngoscopy		T	0073	3.8737	238.43	69.72	47.69
31580	Revision of larynx		T	0256	37.7719	2,324.90		464.98
31582	Revision of larynx		T	0256	37.7719	2,324.90		464.98

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31588	Revision of larynx		T	0256	37.7719	2,324.90		464.98
31590	Reinnervate larynx		T	0256	37.7719	2,324.90		464.98
31595	Larynx nerve surgery		T	0256	37.7719	2,324.90		464.98
31599	Larynx surgery procedure		T	0251	2.3768	146.29		29.26
31600	Incision of windpipe		T	0254	23.1564	1,425.30	321.35	285.06
31601	Incision of windpipe		T	0254	23.1564	1,425.30	321.35	285.06
31603	Incision of windpipe		T	0252	7.7261	475.55	111.84	95.11
31605	Incision of windpipe		T	0252	7.7261	475.55	111.84	95.11
31610	Incision of windpipe		T	0254	23.1564	1,425.30	321.35	285.06
31611	Surgery/speech prosthesis		T	0254	23.1564	1,425.30	321.35	285.06
31612	Puncture/clear windpipe		T	0254	23.1564	1,425.30	321.35	285.06
31613	Repair windpipe opening		T	0254	23.1564	1,425.30	321.35	285.06
31614	Repair windpipe opening		T	0256	37.7719	2,324.90		464.98
31615	Visualization of windpipe		T	0076	9.3905	577.99	189.82	115.60
31620	Endobronchial us add-on		S	0670	29.7322	1,830.05	536.10	366.01
31622	Dx bronchoscope/wash		T	0076	9.3905	577.99	189.82	115.60
31623	Dx bronchoscope/brush		T	0076	9.3905	577.99	189.82	115.60
31624	Dx bronchoscope/lavage		T	0076	9.3905	577.99	189.82	115.60
31625	Bronchoscopy w/biopsy(s)		T	0076	9.3905	577.99	189.82	115.60
31628	Bronchoscopy/lung bx, each		T	0076	9.3905	577.99	189.82	115.60
31629	Bronchoscopy/needle bx, each		T	0076	9.3905	577.99	189.82	115.60
31630	Bronchoscopy dilate/fx repr		T	0415	21.8803	1,346.75	459.92	269.35
31631	Bronchoscopy, dilate w/stent		T	0415	21.8803	1,346.75	459.92	269.35
31632	Bronchoscopy/lung bx, add'l		T	0076	9.3905	577.99	189.82	115.60
31633	Bronchoscopy/needle bx add'l		T	0076	9.3905	577.99	189.82	115.60
31635	Bronchoscopy w/fb removal		T	0076	9.3905	577.99	189.82	115.60
31636	Bronchoscopy, bronch stents		T	0415	21.8803	1,346.75	459.92	269.35
31637	Bronchoscopy, stent add-on		T	0076	9.3905	577.99	189.82	115.60
31638	Bronchoscopy, revise stent		T	0415	21.8803	1,346.75	459.92	269.35
31640	Bronchoscopy w/tumor excise		T	0415	21.8803	1,346.75	459.92	269.35
31641	Bronchoscopy, treat blockage		T	0415	21.8803	1,346.75	459.92	269.35
31643	Diag bronchoscope/catheter		T	0076	9.3905	577.99	189.82	115.60
31645	Bronchoscopy, clear airways		T	0076	9.3905	577.99	189.82	115.60
31646	Bronchoscopy, reclear airway		T	0076	9.3905	577.99	189.82	115.60
31656	Bronchoscopy, inj for x-ray		T	0076	9.3905	577.99	189.82	115.60
31700	Insertion of airway catheter		T	0072	1.4038	86.41	21.27	17.28
31708	Instill airway contrast dye		N					
31710	Insertion of airway catheter		N					
31715	Injection for bronchus x-ray		N					
31717	Bronchial brush biopsy		T	0073	3.8737	238.43	69.72	47.69
31720	Clearance of airways		T	0071	0.7572	46.61	11.03	9.32
31730	Intro, windpipe wire/tube		T	0073	3.8737	238.43	69.72	47.69
31750	Repair of windpipe		T	0256	37.7719	2,324.90		464.98
31755	Repair of windpipe		T	0256	37.7719	2,324.90		464.98
31785	Remove windpipe lesion		T	0254	23.1564	1,425.30	321.35	285.06
31820	Closure of windpipe lesion		T	0253	16.4494	1,012.48	282.29	202.50
31825	Repair of windpipe defect		T	0254	23.1564	1,425.30	321.35	285.06
31830	Revise windpipe scar		T	0254	23.1564	1,425.30	321.35	285.06
31899	Airways surgical procedure		T	0076	9.3905	577.99	189.82	115.60
32000	Drainage of chest		T	0070	3.6425	224.20		44.84
32002	Treatment of collapsed lung		T	0070	3.6425	224.20		44.84
32005	Treat lung lining chemically		T	0070	3.6425	224.20		44.84
32019	Insert pleural catheter	CH	T	0652	29.2259	1,798.88		359.78
32020	Insertion of chest tube		T	0070	3.6425	224.20		44.84
32201	Drain, percut, lung lesion		T	0070	3.6425	224.20		44.84
32400	Needle biopsy chest lining		T	0685	6.0729	373.79	115.47	74.76
32405	Biopsy, lung or mediastinum		T	0685	6.0729	373.79	115.47	74.76
32420	Puncture/clear lung		T	0070	3.6425	224.20		44.84
32601	Thoracoscopy, diagnostic		T	0069	31.5464	1,941.71	591.64	388.34
32602	Thoracoscopy, diagnostic		T	0069	31.5464	1,941.71	591.64	388.34
32603	Thoracoscopy, diagnostic		T	0069	31.5464	1,941.71	591.64	388.34
32604	Thoracoscopy, diagnostic		T	0069	31.5464	1,941.71	591.64	388.34
32605	Thoracoscopy, diagnostic		T	0069	31.5464	1,941.71	591.64	388.34
32606	Thoracoscopy, diagnostic		T	0069	31.5464	1,941.71	591.64	388.34
32960	Therapeutic pneumothorax		T	0070	3.6425	224.20		44.84
32999	Chest surgery procedure		T	0070	3.6425	224.20		44.84
33010	Drainage of heart sac		T	0070	3.6425	224.20		44.84
33011	Repeat drainage of heart sac		T	0070	3.6425	224.20		44.84
33206	Insertion of heart pacemaker		T	0089	121.9402	7,505.54	1,682.28	1,501.11
33207	Insertion of heart pacemaker		T	0089	121.9402	7,505.54	1,682.28	1,501.11

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33208	Insertion of heart pacemaker		T	0655	153.1524	9,426.68		1,885.34
33210	Insertion of heart electrode		T	0106	44.7574	2,754.86		550.97
33211	Insertion of heart electrode		T	0106	44.7574	2,754.86		550.97
33212	Insertion of pulse generator		T	0090	97.8357	6,021.89	1,612.80	1,204.38
33213	Insertion of pulse generator		T	0654	112.2347	6,908.16		1,381.63
33214	Upgrade of pacemaker system		T	0655	153.1524	9,426.68		1,885.34
33215	Reposition pacing-defib lead		T	0105	23.4666	1,444.39	370.40	288.88
33216	Insert lead pace-defib, one		T	0106	44.7574	2,754.86		550.97
33217	Insert lead pace-defib, dual		T	0106	44.7574	2,754.86		550.97
33218	Repair lead pace-defib, one		T	0106	44.7574	2,754.86		550.97
33220	Repair lead pace-defib, dual		T	0106	44.7574	2,754.86		550.97
33222	Revise pocket, pacemaker		T	0027	21.2645	1,308.85	329.72	261.77
33223	Revise pocket, pacing-defib		T	0027	21.2645	1,308.85	329.72	261.77
33224	Insert pacing lead&connect		T	0418	267.8870	16,488.71		3,297.74
33225	L ventric pacing lead add-on		T	0418	267.8870	16,488.71		3,297.74
33226	Reposition l ventric lead		T	0105	23.4666	1,444.39	370.40	288.88
33233	Removal of pacemaker system		T	0105	23.4666	1,444.39	370.40	288.88
33234	Removal of pacemaker system		T	0105	23.4666	1,444.39	370.40	288.88
33235	Removal pacemaker electrode		T	0105	23.4666	1,444.39	370.40	288.88
33241	Remove pulse generator		T	0105	23.4666	1,444.39	370.40	288.88
33244	Remove eltrd, transven		T	0105	23.4666	1,444.39	370.40	288.88
33282	Implant pat-active ht record		S	0680	74.8877	4,609.41		921.88
33284	Remove pat-active ht record		T	0109	10.9541	674.24		134.85
33508	Endoscopic vein harvest		N					
33999	Cardiac surgery procedure		T	0070	3.6425	224.20		44.84
34101	Removal of artery clot		T	0088	37.9652	2,336.80	655.22	467.36
34111	Removal of arm artery clot		T	0088	37.9652	2,336.80	655.22	467.36
34201	Removal of artery clot		T	0088	37.9652	2,336.80	655.22	467.36
34203	Removal of leg artery clot		T	0088	37.9652	2,336.80	655.22	467.36
34421	Removal of vein clot		T	0088	37.9652	2,336.80	655.22	467.36
34471	Removal of vein clot		T	0088	37.9652	2,336.80	655.22	467.36
34490	Removal of vein clot		T	0088	37.9652	2,336.80	655.22	467.36
34501	Repair valve, femoral vein		T	0088	37.9652	2,336.80	655.22	467.36
34510	Transposition of vein valve		T	0088	37.9652	2,336.80	655.22	467.36
34520	Cross-over vein graft		T	0088	37.9652	2,336.80	655.22	467.36
34530	Leg vein fusion		T	0088	37.9652	2,336.80	655.22	467.36
35011	Repair defect of artery		T	0653	31.0004	1,908.11		381.62
35180	Repair blood vessel lesion		T	0093	21.9703	1,352.29		270.46
35184	Repair blood vessel lesion		T	0093	21.9703	1,352.29		270.46
35188	Repair blood vessel lesion		T	0088	37.9652	2,336.80	655.22	467.36
35190	Repair blood vessel lesion		T	0093	21.9703	1,352.29		270.46
35201	Repair blood vessel lesion		T	0093	21.9703	1,352.29		270.46
35206	Repair blood vessel lesion		T	0093	21.9703	1,352.29		270.46
35207	Repair blood vessel lesion		T	0088	37.9652	2,336.80	655.22	467.36
35226	Repair blood vessel lesion		T	0093	21.9703	1,352.29		270.46
35231	Repair blood vessel lesion		T	0093	21.9703	1,352.29		270.46
35236	Repair blood vessel lesion		T	0093	21.9703	1,352.29		270.46
35256	Repair blood vessel lesion		T	0093	21.9703	1,352.29		270.46
35261	Repair blood vessel lesion		T	0653	31.0004	1,908.11		381.62
35266	Repair blood vessel lesion		T	0653	31.0004	1,908.11		381.62
35286	Repair blood vessel lesion		T	0653	31.0004	1,908.11		381.62
35321	Rechanneling of artery		T	0093	21.9703	1,352.29		270.46
35458	Repair arterial blockage		T	0081	42.8894	2,639.89		527.98
35459	Repair arterial blockage		T	0081	42.8894	2,639.89		527.98
35460	Repair venous blockage		T	0081	42.8894	2,639.89		527.98
35470	Repair arterial blockage		T	0081	42.8894	2,639.89		527.98
35471	Repair arterial blockage		T	0081	42.8894	2,639.89		527.98
35472	Repair arterial blockage		T	0081	42.8894	2,639.89		527.98
35473	Repair arterial blockage		T	0081	42.8894	2,639.89		527.98
35474	Repair arterial blockage		T	0081	42.8894	2,639.89		527.98
35475	Repair arterial blockage		T	0081	42.8894	2,639.89		527.98
35476	Repair venous blockage		T	0081	42.8894	2,639.89		527.98
35484	Atherectomy, open		T	0081	42.8894	2,639.89		527.98
35485	Atherectomy, open		T	0081	42.8894	2,639.89		527.98
35490	Atherectomy, percutaneous		T	0081	42.8894	2,639.89		527.98
35491	Atherectomy, percutaneous		T	0081	42.8894	2,639.89		527.98
35492	Atherectomy, percutaneous		T	0081	42.8894	2,639.89		527.98
35493	Atherectomy, percutaneous		T	0081	42.8894	2,639.89		527.98
35494	Atherectomy, percutaneous		T	0081	42.8894	2,639.89		527.98
35495	Atherectomy, percutaneous		T	0081	42.8894	2,639.89		527.98

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35500	Harvest vein for bypass		T	0081	42.8894	2,639.89		527.98
35572	Harvest femoropopliteal vein		N					
35685	Bypass graft patency/patch		T	0093	21.9703	1,352.29		270.46
35686	Bypass graft/av fist patency		T	0093	21.9703	1,352.29		270.46
35761	Exploration of artery/vein		T	0115	29.4757	1,814.26	378.68	362.85
35860	Explore limb vessels		T	0093	21.9703	1,352.29		270.46
35875	Removal of clot in graft		T	0088	37.9652	2,336.80	655.22	467.36
35876	Removal of clot in graft		T	0088	37.9652	2,336.80	655.22	467.36
35879	Revise graft w/vein		T	0088	37.9652	2,336.80	655.22	467.36
35881	Revise graft w/vein		T	0088	37.9652	2,336.80	655.22	467.36
35903	Excision, graft, extremity		T	0115	29.4757	1,814.26	378.68	362.85
36000	Place needle in vein		N					
36002	Pseudoaneurysm injection trt		S	0267	2.5166	154.90	60.80	30.98
36005	Injection ext venography		N					
36010	Place catheter in vein		N					
36011	Place catheter in vein		N					
36012	Place catheter in vein		N					
36013	Place catheter in artery		N					
36014	Place catheter in artery		N					
36015	Place catheter in artery		N					
36100	Establish access to artery		N					
36120	Establish access to artery		N					
36140	Establish access to artery		N					
36145	Artery to vein shunt		N					
36160	Establish access to aorta		N					
36200	Place catheter in aorta		N					
36215	Place catheter in artery		N					
36216	Place catheter in artery		N					
36217	Place catheter in artery		N					
36218	Place catheter in artery		N					
36245	Place catheter in artery		N					
36246	Place catheter in artery		N					
36247	Place catheter in artery		N					
36248	Place catheter in artery		N					
36260	Insertion of infusion pump		T	0623	28.4646	1,752.02		350.40
36261	Revision of infusion pump		T	0623	28.4646	1,752.02		350.40
36262	Removal of infusion pump		T	0622	22.6984	1,397.11		279.42
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					
36416	Capillary blood draw		N					
36420	Vein access cutdown < 1 yr		T	0035	0.2016	12.41		2.48
36425	Vein access cutdown > 1 yr		T	0035	0.2016	12.41		2.48
36430	Blood transfusion service		S	0110	3.4570	212.78		42.56
36440	Bl push transfuse, 2 yr or <		S	0110	3.4570	212.78		42.56
36450	Bl exchange/transfuse, nb		S	0110	3.4570	212.78		42.56
36455	Bl exchange/transfuse non-nb		S	0110	3.4570	212.78		42.56
36460	Transfusion service, fetal		S	0110	3.4570	212.78		42.56
36468	Injection(s), spider veins		T	0098	1.1035	67.92		13.58
36469	Injection(s), spider veins		T	0098	1.1035	67.92		13.58
36470	Injection therapy of vein		T	0098	1.1035	67.92		13.58
36471	Injection therapy of veins		T	0098	1.1035	67.92		13.58
36475	Endovenous rf, 1st vein		T	0091	34.6279	2,131.38		426.28
36476	Endovenous rf, vein add-on		T	0091	34.6279	2,131.38		426.28
36478	Endovenous laser, 1st vein	CH	T	0092	24.5817	1,513.03	306.56	302.61
36479	Endovenous laser vein addon	CH	T	0092	24.5817	1,513.03	306.56	302.61
36481	Insertion of catheter, vein		N					
36500	Insertion of catheter, vein		N					
36510	Insertion of catheter, vein		N					
36511	Apheresis wbc		S	0111	11.7005	720.18	198.40	144.04
36512	Apheresis rbc		S	0111	11.7005	720.18	198.40	144.04
36513	Apheresis platelets		S	0111	11.7005	720.18	198.40	144.04
36514	Apheresis plasma		S	0111	11.7005	720.18	198.40	144.04
36515	Apheresis, adsorp/reinfuse		S	0112	30.6602	1,887.17	433.29	377.43
36516	Apheresis, selective		S	0112	30.6602	1,887.17	433.29	377.43
36522	Photopheresis		S	0112	30.6602	1,887.17	433.29	377.43
36540	Collect blood venous device	CH	Q	0624	0.5336	32.84	13.13	6.57
36550	Declot vascular device		T	0676	2.0612	126.87		25.37

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36555	Insert non-tunnel cv cath		T	0621	8.7841	540.67		108.13
36556	Insert non-tunnel cv cath		T	0621	8.7841	540.67		108.13
36557	Insert tunneled cv cath		T	0622	22.6984	1,397.11		279.42
36558	Insert tunneled cv cath		T	0622	22.6984	1,397.11		279.42
36560	Insert tunneled cv cath		T	0623	28.4646	1,752.02		350.40
36561	Insert tunneled cv cath		T	0623	28.4646	1,752.02		350.40
36563	Insert tunneled cv cath		T	0623	28.4646	1,752.02		350.40
36565	Insert tunneled cv cath		T	0623	28.4646	1,752.02		350.40
36566	Insert tunneled cv cath	CH	T	0623	28.4646	1,752.02		350.40
36568	Insert picc cath		T	0621	8.7841	540.67		108.13
36569	Insert picc cath		T	0621	8.7841	540.67		108.13
36570	Insert picvad cath		T	0622	22.6984	1,397.11		279.42
36571	Insert picvad cath		T	0622	22.6984	1,397.11		279.42
36575	Repair tunneled cv cath		T	0621	8.7841	540.67		108.13
36576	Repair tunneled cv cath		T	0621	8.7841	540.67		108.13
36578	Replace tunneled cv cath		T	0622	22.6984	1,397.11		279.42
36580	Replace cvad cath		T	0621	8.7841	540.67		108.13
36581	Replace tunneled cv cath		T	0622	22.6984	1,397.11		279.42
36582	Replace tunneled cv cath		T	0623	28.4646	1,752.02		350.40
36583	Replace tunneled cv cath		T	0623	28.4646	1,752.02		350.40
36584	Replace picc cath		T	0621	8.7841	540.67		108.13
36585	Replace picvad cath		T	0622	22.6984	1,397.11		279.42
36589	Removal tunneled cv cath		T	0621	8.7841	540.67		108.13
36590	Removal tunneled cv cath		T	0621	8.7841	540.67		108.13
36595	Mech remov tunneled cv cath		T	0622	22.6984	1,397.11		279.42
36596	Mech remov tunneled cv cath		T	0621	8.7841	540.67		108.13
36597	Reposition venous catheter		T	0621	8.7841	540.67		108.13
36598	Inj w/fluor, eval cv device		X	0340	0.6211	38.23		7.65
36600	Withdrawal of arterial blood	CH	Q	0035	0.2016	12.41		2.48
36620	Insertion catheter, artery		N					
36625	Insertion catheter, artery		N					
36640	Insertion catheter, artery		T	0623	28.4646	1,752.02		350.40
36680	Insert needle, bone cavity		T	0002	1.0948	67.39		13.48
36800	Insertion of cannula		T	0115	29.4757	1,814.26	378.68	362.85
36810	Insertion of cannula		T	0115	29.4757	1,814.26	378.68	362.85
36815	Insertion of cannula		T	0115	29.4757	1,814.26	378.68	362.85
36818	Av fuse, uppr arm, cephalic		T	0088	37.9652	2,336.80	655.22	467.36
36819	Av fuse, uppr arm, basilic		T	0088	37.9652	2,336.80	655.22	467.36
36820	Av fusion/forearm vein		T	0088	37.9652	2,336.80	655.22	467.36
36821	Av fusion direct any site		T	0088	37.9652	2,336.80	655.22	467.36
36825	Artery-vein autograft		T	0088	37.9652	2,336.80	655.22	467.36
36830	Artery-vein nonautograft		T	0088	37.9652	2,336.80	655.22	467.36
36831	Open thrombect av fistula		T	0088	37.9652	2,336.80	655.22	467.36
36832	Av fistula revision, open		T	0088	37.9652	2,336.80	655.22	467.36
36833	Av fistula revision		T	0088	37.9652	2,336.80	655.22	467.36
36834	Repair A-V aneurysm		T	0088	37.9652	2,336.80	655.22	467.36
36835	Artery to vein shunt		T	0115	29.4757	1,814.26	378.68	362.85
36838	Dist revas ligation, hemo		T	0088	37.9652	2,336.80	655.22	467.36
36860	External cannula declotting		T	0676	2.0612	126.87		25.37
36861	Cannula declotting		T	0115	29.4757	1,814.26	378.68	362.85
36870	Percut thrombect av fistula		T	0653	31.0004	1,908.11		381.62
37183	Remove hepatic shunt (tips)		T	0229	66.0804	4,067.31		813.46
37184	Prim art mech thrombectomy		T	0653	31.0004	1,908.11		381.62
37185	Prim art m-thrombect add-on		T	0103	17.0436	1,049.05	223.63	209.81
37186	Sec art m-thrombect add-on		T	0103	17.0436	1,049.05	223.63	209.81
37187	Venous mech thrombectomy		T	0653	31.0004	1,908.11		381.62
37188	Venous m-thrombectomy add-on		T	0653	31.0004	1,908.11		381.62
37195	Thrombolytic therapy, stroke		T	0676	2.0612	126.87		25.37
37200	Transcatheter biopsy		T	0685	6.0729	373.79	115.47	74.76
37201	Transcatheter therapy infuse		T	0676	2.0612	126.87		25.37
37202	Transcatheter therapy infuse		T	0676	2.0612	126.87		25.37
37203	Transcatheter retrieval		T	0103	17.0436	1,049.05	223.63	209.81
37204	Transcatheter occlusion		T	0115	29.4757	1,814.26	378.68	362.85
37205	Transcath iv stent, percut		T	0229	66.0804	4,067.31		813.46
37206	Transcath iv stent/perc addl		T	0229	66.0804	4,067.31		813.46
37207	Transcath iv stent, open		T	0229	66.0804	4,067.31		813.46
37208	Transcath iv stent/open addl		T	0229	66.0804	4,067.31		813.46
37209	Change iv cath at thromb tx		T	0103	17.0436	1,049.05	223.63	209.81
37250	Iv us first vessel add-on		S	0416	32.2182	1,983.06		396.61
37251	Iv us each add vessel add-on		S	0416	32.2182	1,983.06		396.61

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
37500	Endoscopy ligate perf veins	CH	T	0091	34.6279	2,131.38		426.28
37501	Vascular endoscopy procedure		T	0092	24.5817	1,513.03	306.56	302.61
37565	Ligation of neck vein		T	0093	21.9703	1,352.29		270.46
37600	Ligation of neck artery		T	0093	21.9703	1,352.29		270.46
37605	Ligation of neck artery		T	0091	34.6279	2,131.38		426.28
37606	Ligation of neck artery	CH	T	0092	24.5817	1,513.03	306.56	302.61
37607	Ligation of a-v fistula		T	0092	24.5817	1,513.03	306.56	302.61
37609	Temporal artery procedure		T	0021	14.9563	920.58	219.48	184.12
37615	Ligation of neck artery	CH	T	0092	24.5817	1,513.03	306.56	302.61
37620	Revision of major vein		T	0091	34.6279	2,131.38		426.28
37650	Revision of major vein	CH	T	0092	24.5817	1,513.03	306.56	302.61
37700	Revise leg vein		T	0091	34.6279	2,131.38		426.28
37718	Ligate/strip short leg vein	CH	T	0091	34.6279	2,131.38		426.28
37722	Ligate/strip long leg vein	CH	T	0091	34.6279	2,131.38		426.28
37735	Removal of leg veins/lesion	CH	T	0091	34.6279	2,131.38		426.28
37760	Ligation, leg veins, open	CH	T	0092	24.5817	1,513.03	306.56	302.61
37765	Phleb veins - extrem - to 20	CH	T	0092	24.5817	1,513.03	306.56	302.61
37766	Phleb veins - extrem 20+	CH	T	0092	24.5817	1,513.03	306.56	302.61
37780	Revision of leg vein	CH	T	0092	24.5817	1,513.03	306.56	302.61
37785	Ligate/divide/excise vein	CH	T	0092	24.5817	1,513.03	306.56	302.61
37790	Penile venous occlusion		T	0181	32.9991	2,031.13	621.82	406.23
37799	Vascular surgery procedure		T	0103	17.0436	1,049.05	223.63	209.81
38120	Laparoscopy, splenectomy		T	0131	43.5124	2,678.23	1,001.89	535.65
38129	Laparoscope proc, spleen		T	0130	31.9353	1,965.65	659.53	393.13
38200	Injection for spleen x-ray		N					
38204	Bl donor search management		N					
38205	Harvest allogenic stem cells		S	0111	11.7005	720.18	198.40	144.04
38206	Harvest auto stem cells		S	0111	11.7005	720.18	198.40	144.04
38220	Bone marrow aspiration		T	0003	2.4295	149.54		29.91
38221	Bone marrow biopsy		T	0003	2.4295	149.54		29.91
38230	Bone marrow collection		S	0123	23.2490	1,431.00		286.20
38240	Bone marrow/stem transplant		S	0123	23.2490	1,431.00		286.20
38241	Bone marrow/stem transplant		S	0123	23.2490	1,431.00		286.20
38242	Lymphocyte infuse transplant		S	0111	11.7005	720.18	198.40	144.04
38300	Drainage, lymph node lesion		T	0007	10.9184	672.04		134.41
38305	Drainage, lymph node lesion		T	0008	17.4686	1,075.21		215.04
38308	Incision of lymph channels		T	0113	21.3673	1,315.18		263.04
38500	Biopsy/removal, lymph nodes		T	0113	21.3673	1,315.18		263.04
38505	Needle biopsy, lymph nodes		T	0005	3.8051	234.21	71.59	46.84
38510	Biopsy/removal, lymph nodes		T	0113	21.3673	1,315.18		263.04
38520	Biopsy/removal, lymph nodes		T	0113	21.3673	1,315.18		263.04
38525	Biopsy/removal, lymph nodes		T	0113	21.3673	1,315.18		263.04
38530	Biopsy/removal, lymph nodes		T	0113	21.3673	1,315.18		263.04
38542	Explore deep node(s), neck		T	0114	37.1283	2,285.28	461.19	457.06
38550	Removal, neck/armpit lesion		T	0113	21.3673	1,315.18		263.04
38555	Removal, neck/armpit lesion		T	0113	21.3673	1,315.18		263.04
38570	Laparoscopy, lymph node biop		T	0131	43.5124	2,678.23	1,001.89	535.65
38571	Laparoscopy, lymphadenectomy		T	0132	70.8854	4,363.07	1,239.22	872.61
38572	Laparoscopy, lymphadenectomy		T	0131	43.5124	2,678.23	1,001.89	535.65
38589	Laparoscope proc, lymphatic		T	0130	31.9353	1,965.65	659.53	393.13
38700	Removal of lymph nodes, neck		T	0113	21.3673	1,315.18		263.04
38720	Removal of lymph nodes, neck		T	0113	21.3673	1,315.18		263.04
38740	Remove armpit lymph nodes		T	0114	37.1283	2,285.28	461.19	457.06
38745	Remove armpit lymph nodes		T	0114	37.1283	2,285.28	461.19	457.06
38760	Remove groin lymph nodes		T	0113	21.3673	1,315.18		263.04
38790	Inject for lymphatic x-ray		N					
38792	Identify sentinel node	CH	Q	0389	1.4072	86.61	33.98	17.32
38794	Access thoracic lymph duct		N					
38999	Blood/lymph system procedure		S	0110	3.4570	212.78		42.56
39400	Visualization of chest		T	0069	31.5464	1,941.71	591.64	388.34
40490	Biopsy of lip		T	0251	2.3768	146.29		29.26
40500	Partial excision of lip		T	0253	16.4494	1,012.48	282.29	202.50
40510	Partial excision of lip		T	0254	23.1564	1,425.30	321.35	285.06
40520	Partial excision of lip		T	0253	16.4494	1,012.48	282.29	202.50
40525	Reconstruct lip with flap		T	0254	23.1564	1,425.30	321.35	285.06
40527	Reconstruct lip with flap		T	0254	23.1564	1,425.30	321.35	285.06
40530	Partial removal of lip		T	0254	23.1564	1,425.30	321.35	285.06
40650	Repair lip		T	0252	7.7261	475.55	111.84	95.11
40652	Repair lip		T	0252	7.7261	475.55	111.84	95.11
40654	Repair lip		T	0252	7.7261	475.55	111.84	95.11

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
40700	Repair cleft lip/nasal		T	0256	37.7719	2,324.90		464.98
40701	Repair cleft lip/nasal		T	0256	37.7719	2,324.90		464.98
40702	Repair cleft lip/nasal		T	0256	37.7719	2,324.90		464.98
40720	Repair cleft lip/nasal		T	0256	37.7719	2,324.90		464.98
40761	Repair cleft lip/nasal		T	0256	37.7719	2,324.90		464.98
40799	Lip surgery procedure		T	0251	2.3768	146.29		29.26
40800	Drainage of mouth lesion	CH	T	0006	1.4821	91.22	21.76	18.24
40801	Drainage of mouth lesion		T	0252	7.7261	475.55	111.84	95.11
40804	Removal, foreign body, mouth		X	0340	0.6211	38.23		7.65
40805	Removal, foreign body, mouth		T	0252	7.7261	475.55	111.84	95.11
40806	Incision of lip fold		T	0251	2.3768	146.29		29.26
40808	Biopsy of mouth lesion		T	0251	2.3768	146.29		29.26
40810	Excision of mouth lesion		T	0253	16.4494	1,012.48	282.29	202.50
40812	Excise/repair mouth lesion		T	0253	16.4494	1,012.48	282.29	202.50
40814	Excise/repair mouth lesion		T	0253	16.4494	1,012.48	282.29	202.50
40816	Excision of mouth lesion		T	0254	23.1564	1,425.30	321.35	285.06
40818	Excise oral mucosa for graft		T	0251	2.3768	146.29		29.26
40819	Excise lip or cheek fold		T	0252	7.7261	475.55	111.84	95.11
40820	Treatment of mouth lesion		T	0253	16.4494	1,012.48	282.29	202.50
40830	Repair mouth laceration		T	0251	2.3768	146.29		29.26
40831	Repair mouth laceration		T	0252	7.7261	475.55	111.84	95.11
40840	Reconstruction of mouth		T	0254	23.1564	1,425.30	321.35	285.06
40842	Reconstruction of mouth		T	0254	23.1564	1,425.30	321.35	285.06
40843	Reconstruction of mouth		T	0254	23.1564	1,425.30	321.35	285.06
40844	Reconstruction of mouth		T	0256	37.7719	2,324.90		464.98
40845	Reconstruction of mouth		T	0256	37.7719	2,324.90		464.98
40899	Mouth surgery procedure		T	0251	2.3768	146.29		29.26
41000	Drainage of mouth lesion		T	0253	16.4494	1,012.48	282.29	202.50
41005	Drainage of mouth lesion		T	0251	2.3768	146.29		29.26
41006	Drainage of mouth lesion		T	0254	23.1564	1,425.30	321.35	285.06
41007	Drainage of mouth lesion		T	0253	16.4494	1,012.48	282.29	202.50
41008	Drainage of mouth lesion		T	0253	16.4494	1,012.48	282.29	202.50
41009	Drainage of mouth lesion		T	0251	2.3768	146.29		29.26
41010	Incision of tongue fold		T	0252	7.7261	475.55	111.84	95.11
41015	Drainage of mouth lesion		T	0251	2.3768	146.29		29.26
41016	Drainage of mouth lesion		T	0252	7.7261	475.55	111.84	95.11
41017	Drainage of mouth lesion		T	0252	7.7261	475.55	111.84	95.11
41018	Drainage of mouth lesion		T	0252	7.7261	475.55	111.84	95.11
41100	Biopsy of tongue		T	0252	7.7261	475.55	111.84	95.11
41105	Biopsy of tongue		T	0253	16.4494	1,012.48	282.29	202.50
41108	Biopsy of floor of mouth		T	0252	7.7261	475.55	111.84	95.11
41110	Excision of tongue lesion		T	0253	16.4494	1,012.48	282.29	202.50
41112	Excision of tongue lesion		T	0253	16.4494	1,012.48	282.29	202.50
41113	Excision of tongue lesion		T	0253	16.4494	1,012.48	282.29	202.50
41114	Excision of tongue lesion		T	0254	23.1564	1,425.30	321.35	285.06
41115	Excision of tongue fold		T	0252	7.7261	475.55	111.84	95.11
41116	Excision of mouth lesion		T	0253	16.4494	1,012.48	282.29	202.50
41120	Partial removal of tongue		T	0254	23.1564	1,425.30	321.35	285.06
41250	Repair tongue laceration		T	0251	2.3768	146.29		29.26
41251	Repair tongue laceration		T	0251	2.3768	146.29		29.26
41252	Repair tongue laceration		T	0252	7.7261	475.55	111.84	95.11
41500	Fixation of tongue		T	0254	23.1564	1,425.30	321.35	285.06
41510	Tongue to lip surgery		T	0253	16.4494	1,012.48	282.29	202.50
41520	Reconstruction, tongue fold		T	0252	7.7261	475.55	111.84	95.11
41599	Tongue and mouth surgery		T	0251	2.3768	146.29		29.26
41800	Drainage of gum lesion	CH	T	0006	1.4821	91.22	21.76	18.24
41805	Removal foreign body, gum		T	0254	23.1564	1,425.30	321.35	285.06
41806	Removal foreign body,jawbone		T	0253	16.4494	1,012.48	282.29	202.50
41820	Excision, gum, each quadrant		T	0252	7.7261	475.55	111.84	95.11
41821	Excision of gum flap		T	0252	7.7261	475.55	111.84	95.11
41822	Excision of gum lesion		T	0253	16.4494	1,012.48	282.29	202.50
41823	Excision of gum lesion		T	0254	23.1564	1,425.30	321.35	285.06
41825	Excision of gum lesion		T	0253	16.4494	1,012.48	282.29	202.50
41826	Excision of gum lesion		T	0253	16.4494	1,012.48	282.29	202.50
41827	Excision of gum lesion		T	0254	23.1564	1,425.30	321.35	285.06
41828	Excision of gum lesion		T	0253	16.4494	1,012.48	282.29	202.50
41830	Removal of gum tissue		T	0253	16.4494	1,012.48	282.29	202.50
41850	Treatment of gum lesion		T	0253	16.4494	1,012.48	282.29	202.50
41870	Gum graft		T	0254	23.1564	1,425.30	321.35	285.06
41872	Repair gum		T	0253	16.4494	1,012.48	282.29	202.50

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
41874	Repair tooth socket		T	0254	23.1564	1,425.30	321.35	285.06
41899	Dental surgery procedure		T	0251	2.3768	146.29		29.26
42000	Drainage mouth roof lesion		T	0251	2.3768	146.29		29.26
42100	Biopsy roof of mouth		T	0252	7.7261	475.55	111.84	95.11
42104	Excision lesion, mouth roof		T	0253	16.4494	1,012.48	282.29	202.50
42106	Excision lesion, mouth roof		T	0253	16.4494	1,012.48	282.29	202.50
42107	Excision lesion, mouth roof		T	0254	23.1564	1,425.30	321.35	285.06
42120	Remove palate/lesion		T	0256	37.7719	2,324.90		464.98
42140	Excision of uvula		T	0252	7.7261	475.55	111.84	95.11
42145	Repair palate, pharynx/uvula		T	0254	23.1564	1,425.30	321.35	285.06
42160	Treatment mouth roof lesion		T	0253	16.4494	1,012.48	282.29	202.50
42180	Repair palate		T	0251	2.3768	146.29		29.26
42182	Repair palate		T	0256	37.7719	2,324.90		464.98
42200	Reconstruct cleft palate		T	0256	37.7719	2,324.90		464.98
42205	Reconstruct cleft palate		T	0256	37.7719	2,324.90		464.98
42210	Reconstruct cleft palate		T	0256	37.7719	2,324.90		464.98
42215	Reconstruct cleft palate		T	0256	37.7719	2,324.90		464.98
42220	Reconstruct cleft palate		T	0256	37.7719	2,324.90		464.98
42225	Reconstruct cleft palate		T	0256	37.7719	2,324.90		464.98
42226	Lengthening of palate		T	0256	37.7719	2,324.90		464.98
42227	Lengthening of palate		T	0256	37.7719	2,324.90		464.98
42235	Repair palate		T	0253	16.4494	1,012.48	282.29	202.50
42260	Repair nose to lip fistula		T	0254	23.1564	1,425.30	321.35	285.06
42280	Preparation, palate mold		T	0251	2.3768	146.29		29.26
42281	Insertion, palate prosthesis		T	0253	16.4494	1,012.48	282.29	202.50
42299	Palate/uvula surgery		T	0251	2.3768	146.29		29.26
42300	Drainage of salivary gland		T	0253	16.4494	1,012.48	282.29	202.50
42305	Drainage of salivary gland		T	0253	16.4494	1,012.48	282.29	202.50
42310	Drainage of salivary gland		T	0251	2.3768	146.29		29.26
42320	Drainage of salivary gland		T	0251	2.3768	146.29		29.26
42330	Removal of salivary stone		T	0253	16.4494	1,012.48	282.29	202.50
42335	Removal of salivary stone		T	0253	16.4494	1,012.48	282.29	202.50
42340	Removal of salivary stone		T	0253	16.4494	1,012.48	282.29	202.50
42400	Biopsy of salivary gland		T	0005	3.8051	234.21	71.59	46.84
42405	Biopsy of salivary gland		T	0253	16.4494	1,012.48	282.29	202.50
42408	Excision of salivary cyst		T	0253	16.4494	1,012.48	282.29	202.50
42409	Drainage of salivary cyst		T	0253	16.4494	1,012.48	282.29	202.50
42410	Excise parotid gland/lesion		T	0256	37.7719	2,324.90		464.98
42415	Excise parotid gland/lesion		T	0256	37.7719	2,324.90		464.98
42420	Excise parotid gland/lesion		T	0256	37.7719	2,324.90		464.98
42425	Excise parotid gland/lesion		T	0256	37.7719	2,324.90		464.98
42440	Excise submaxillary gland		T	0256	37.7719	2,324.90		464.98
42450	Excise sublingual gland		T	0254	23.1564	1,425.30	321.35	285.06
42500	Repair salivary duct		T	0254	23.1564	1,425.30	321.35	285.06
42505	Repair salivary duct		T	0256	37.7719	2,324.90		464.98
42507	Parotid duct diversion		T	0256	37.7719	2,324.90		464.98
42508	Parotid duct diversion		T	0256	37.7719	2,324.90		464.98
42509	Parotid duct diversion		T	0256	37.7719	2,324.90		464.98
42510	Parotid duct diversion		T	0256	37.7719	2,324.90		464.98
42550	Injection for salivary x-ray		N					
42600	Closure of salivary fistula		T	0253	16.4494	1,012.48	282.29	202.50
42650	Dilation of salivary duct		T	0252	7.7261	475.55	111.84	95.11
42660	Dilation of salivary duct		T	0251	2.3768	146.29		29.26
42665	Ligation of salivary duct		T	0254	23.1564	1,425.30	321.35	285.06
42699	Salivary surgery procedure		T	0251	2.3768	146.29		29.26
42700	Drainage of tonsil abscess		T	0251	2.3768	146.29		29.26
42720	Drainage of throat abscess		T	0253	16.4494	1,012.48	282.29	202.50
42725	Drainage of throat abscess		T	0256	37.7719	2,324.90		464.98
42800	Biopsy of throat	CH	T	0252	7.7261	475.55	111.84	95.11
42802	Biopsy of throat		T	0253	16.4494	1,012.48	282.29	202.50
42804	Biopsy of upper nose/throat		T	0253	16.4494	1,012.48	282.29	202.50
42806	Biopsy of upper nose/throat		T	0254	23.1564	1,425.30	321.35	285.06
42808	Excise pharynx lesion		T	0253	16.4494	1,012.48	282.29	202.50
42809	Remove pharynx foreign body		X	0340	0.6211	38.23		7.65
42810	Excision of neck cyst		T	0254	23.1564	1,425.30	321.35	285.06
42815	Excision of neck cyst		T	0256	37.7719	2,324.90		464.98
42820	Remove tonsils and adenoids		T	0258	22.7757	1,401.87	437.25	280.37
42821	Remove tonsils and adenoids		T	0258	22.7757	1,401.87	437.25	280.37
42825	Removal of tonsils		T	0258	22.7757	1,401.87	437.25	280.37
42826	Removal of tonsils		T	0258	22.7757	1,401.87	437.25	280.37

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42830	Removal of adenoids		T	0258	22.7757	1,401.87	437.25	280.37
42831	Removal of adenoids		T	0258	22.7757	1,401.87	437.25	280.37
42835	Removal of adenoids		T	0258	22.7757	1,401.87	437.25	280.37
42836	Removal of adenoids		T	0258	22.7757	1,401.87	437.25	280.37
42842	Extensive surgery of throat		T	0254	23.1564	1,425.30	321.35	285.06
42844	Extensive surgery of throat		T	0256	37.7719	2,324.90		464.98
42860	Excision of tonsil tags		T	0258	22.7757	1,401.87	437.25	280.37
42870	Excision of lingual tonsil		T	0258	22.7757	1,401.87	437.25	280.37
42890	Partial removal of pharynx		T	0256	37.7719	2,324.90		464.98
42892	Revision of pharyngeal walls		T	0256	37.7719	2,324.90		464.98
42900	Repair throat wound		T	0252	7.7261	475.55	111.84	95.11
42950	Reconstruction of throat		T	0254	23.1564	1,425.30	321.35	285.06
42955	Surgical opening of throat		T	0254	23.1564	1,425.30	321.35	285.06
42960	Control throat bleeding		T	0250	1.2021	73.99	25.50	14.80
42962	Control throat bleeding		T	0256	37.7719	2,324.90		464.98
42970	Control nose/throat bleeding		T	0250	1.2021	73.99	25.50	14.80
42972	Control nose/throat bleeding		T	0253	16.4494	1,012.48	282.29	202.50
42999	Throat surgery procedure		T	0251	2.3768	146.29		29.26
43020	Incision of esophagus		T	0252	7.7261	475.55	111.84	95.11
43030	Throat muscle surgery		T	0253	16.4494	1,012.48	282.29	202.50
43130	Removal of esophagus pouch	CH	T	0256	37.7719	2,324.90		464.98
43200	Esophagus endoscopy		T	0141	8.3070	511.30	143.38	102.26
43201	Esoph scope w/submucous inj		T	0141	8.3070	511.30	143.38	102.26
43202	Esophagus endoscopy, biopsy		T	0141	8.3070	511.30	143.38	102.26
43204	Esoph scope w/sclerosis inj		T	0141	8.3070	511.30	143.38	102.26
43205	Esophagus endoscopy/ligation		T	0141	8.3070	511.30	143.38	102.26
43215	Esophagus endoscopy		T	0141	8.3070	511.30	143.38	102.26
43216	Esophagus endoscopy/lesion		T	0141	8.3070	511.30	143.38	102.26
43217	Esophagus endoscopy		T	0141	8.3070	511.30	143.38	102.26
43219	Esophagus endoscopy		T	0384	22.6777	1,395.84	292.31	279.17
43220	Esoph endoscopy, dilation		T	0141	8.3070	511.30	143.38	102.26
43226	Esoph endoscopy, dilation		T	0141	8.3070	511.30	143.38	102.26
43227	Esoph endoscopy, repair		T	0141	8.3070	511.30	143.38	102.26
43228	Esoph endoscopy, ablation		T	0422	27.5493	1,695.69	448.81	339.14
43231	Esoph endoscopy w/us exam		T	0141	8.3070	511.30	143.38	102.26
43232	Esoph endoscopy w/us fn bx		T	0141	8.3070	511.30	143.38	102.26
43234	Upper GI endoscopy, exam		T	0141	8.3070	511.30	143.38	102.26
43235	Uppr gi endoscopy, diagnosis		T	0141	8.3070	511.30	143.38	102.26
43236	Uppr gi scope w/submuc inj		T	0141	8.3070	511.30	143.38	102.26
43237	Endoscopic us exam, esoph		T	0141	8.3070	511.30	143.38	102.26
43238	Uppr gi endoscopy w/us fn bx		T	0141	8.3070	511.30	143.38	102.26
43239	Upper GI endoscopy, biopsy		T	0141	8.3070	511.30	143.38	102.26
43240	Esoph endoscope w/drain cyst		T	0141	8.3070	511.30	143.38	102.26
43241	Upper GI endoscopy with tube		T	0141	8.3070	511.30	143.38	102.26
43242	Uppr gi endoscopy w/us fn bx		T	0141	8.3070	511.30	143.38	102.26
43243	Upper gi endoscopy&inject		T	0141	8.3070	511.30	143.38	102.26
43244	Upper GI endoscopy/ligation		T	0141	8.3070	511.30	143.38	102.26
43245	Uppr gi scope dilate strictr		T	0141	8.3070	511.30	143.38	102.26
43246	Place gastrostomy tube		T	0141	8.3070	511.30	143.38	102.26
43247	Operative upper GI endoscopy		T	0141	8.3070	511.30	143.38	102.26
43248	Uppr gi endoscopy/guide wire		T	0141	8.3070	511.30	143.38	102.26
43249	Esoph endoscopy, dilation		T	0141	8.3070	511.30	143.38	102.26
43250	Upper GI endoscopy/tumor		T	0141	8.3070	511.30	143.38	102.26
43251	Operative upper GI endoscopy		T	0141	8.3070	511.30	143.38	102.26
43255	Operative upper GI endoscopy		T	0141	8.3070	511.30	143.38	102.26
43256	Uppr gi endoscopy w/stent		T	0384	22.6777	1,395.84	292.31	279.17
43257	Uppr gi scope w/thrml txmnt		T	0422	27.5493	1,695.69	448.81	339.14
43258	Operative upper GI endoscopy		T	0141	8.3070	511.30	143.38	102.26
43259	Endoscopic ultrasound exam		T	0141	8.3070	511.30	143.38	102.26
43260	Endo cholangiopancreatograph		T	0151	19.8125	1,219.48	245.46	243.90
43261	Endo cholangiopancreatograph		T	0151	19.8125	1,219.48	245.46	243.90
43262	Endo cholangiopancreatograph		T	0151	19.8125	1,219.48	245.46	243.90
43263	Endo cholangiopancreatograph		T	0151	19.8125	1,219.48	245.46	243.90
43264	Endo cholangiopancreatograph		T	0151	19.8125	1,219.48	245.46	243.90
43265	Endo cholangiopancreatograph		T	0151	19.8125	1,219.48	245.46	243.90
43267	Endo cholangiopancreatograph		T	0151	19.8125	1,219.48	245.46	243.90
43268	Endo cholangiopancreatograph		T	0384	22.6777	1,395.84	292.31	279.17
43269	Endo cholangiopancreatograph		T	0384	22.6777	1,395.84	292.31	279.17
43271	Endo cholangiopancreatograph		T	0151	19.8125	1,219.48	245.46	243.90
43272	Endo cholangiopancreatograph		T	0151	19.8125	1,219.48	245.46	243.90

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43280	Laparoscopy, fundoplasty		T	0132	70.8854	4,363.07	1,239.22	872.61
43289	Laparoscope proc, esoph		T	0130	31.9353	1,965.65	659.53	393.13
43450	Dilate esophagus		T	0140	5.3134	327.05	91.40	65.41
43453	Dilate esophagus		T	0140	5.3134	327.05	91.40	65.41
43456	Dilate esophagus		T	0140	5.3134	327.05	91.40	65.41
43458	Dilate esophagus		T	0140	5.3134	327.05	91.40	65.41
43499	Esophagus surgery procedure		T	0141	8.3070	511.30	143.38	102.26
43510	Surgical opening of stomach		T	0141	8.3070	511.30	143.38	102.26
43600	Biopsy of stomach		T	0141	8.3070	511.30	143.38	102.26
43651	Laparoscopy, vagus nerve		T	0132	70.8854	4,363.07	1,239.22	872.61
43652	Laparoscopy, vagus nerve		T	0132	70.8854	4,363.07	1,239.22	872.61
43653	Laparoscopy, gastrostomy		T	0131	43.5124	2,678.23	1,001.89	535.65
43659	Laparoscope proc, stom		T	0130	31.9353	1,965.65	659.53	393.13
43750	Place gastrostomy tube		T	0141	8.3070	511.30	143.38	102.26
43752	Nasal/orogastric w/stent		X	0272	1.2985	79.92	31.64	15.98
43760	Change gastrostomy tube		T	0121	2.3431	144.22	43.80	28.84
43761	Reposition gastrostomy tube		T	0122	7.2859	448.45		89.69
43830	Place gastrostomy tube		T	0422	27.5493	1,695.69	448.81	339.14
43831	Place gastrostomy tube		T	0141	8.3070	511.30	143.38	102.26
43870	Repair stomach opening		T	0141	8.3070	511.30	143.38	102.26
43886	Revise gastric port, open		T	0025	5.0931	313.49	95.46	62.70
43887	Remove gastric port, open		T	0025	5.0931	313.49	95.46	62.70
43888	Change gastric port, open		T	0686	13.3433	821.29		164.26
43999	Stomach surgery procedure		T	0141	8.3070	511.30	143.38	102.26
44100	Biopsy of bowel		T	0141	8.3070	511.30	143.38	102.26
44180	Lap, enterolysis		T	0131	43.5124	2,678.23	1,001.89	535.65
44186	Lap, jejunostomy		T	0131	43.5124	2,678.23	1,001.89	535.65
44206	Lap part colectomy w/stoma		T	0132	70.8854	4,363.07	1,239.22	872.61
44207	L colectomy/coloproctostomy		T	0132	70.8854	4,363.07	1,239.22	872.61
44208	L colectomy/coloproctostomy		T	0132	70.8854	4,363.07	1,239.22	872.61
44213	Lap, mobil splenic fl add-on		T	0130	31.9353	1,965.65	659.53	393.13
44238	Laparoscope proc, intestine		T	0130	31.9353	1,965.65	659.53	393.13
44312	Revision of ileostomy		T	0027	21.2645	1,308.85	329.72	261.77
44340	Revision of colostomy		T	0027	21.2645	1,308.85	329.72	261.77
44360	Small bowel endoscopy		T	0142	9.3878	577.83	152.78	115.57
44361	Small bowel endoscopy/biopsy		T	0142	9.3878	577.83	152.78	115.57
44363	Small bowel endoscopy		T	0142	9.3878	577.83	152.78	115.57
44364	Small bowel endoscopy		T	0142	9.3878	577.83	152.78	115.57
44365	Small bowel endoscopy		T	0142	9.3878	577.83	152.78	115.57
44366	Small bowel endoscopy		T	0142	9.3878	577.83	152.78	115.57
44369	Small bowel endoscopy		T	0142	9.3878	577.83	152.78	115.57
44370	Small bowel endoscopy/stent		T	0384	22.6777	1,395.84	292.31	279.17
44372	Small bowel endoscopy		T	0142	9.3878	577.83	152.78	115.57
44373	Small bowel endoscopy		T	0142	9.3878	577.83	152.78	115.57
44376	Small bowel endoscopy		T	0142	9.3878	577.83	152.78	115.57
44377	Small bowel endoscopy/biopsy		T	0142	9.3878	577.83	152.78	115.57
44378	Small bowel endoscopy		T	0142	9.3878	577.83	152.78	115.57
44379	S bowel endoscope w/stent		T	0384	22.6777	1,395.84	292.31	279.17
44380	Small bowel endoscopy		T	0142	9.3878	577.83	152.78	115.57
44382	Small bowel endoscopy		T	0142	9.3878	577.83	152.78	115.57
44383	Ileoscopy w/stent		T	0384	22.6777	1,395.84	292.31	279.17
44385	Endoscopy of bowel pouch		T	0143	8.8143	542.53	186.06	108.51
44386	Endoscopy, bowel pouch/biop		T	0143	8.8143	542.53	186.06	108.51
44388	Colonoscopy		T	0143	8.8143	542.53	186.06	108.51
44389	Colonoscopy with biopsy		T	0143	8.8143	542.53	186.06	108.51
44390	Colonoscopy for foreign body		T	0143	8.8143	542.53	186.06	108.51
44391	Colonoscopy for bleeding		T	0143	8.8143	542.53	186.06	108.51
44392	Colonoscopy&polypectomy		T	0143	8.8143	542.53	186.06	108.51
44393	Colonoscopy, lesion removal		T	0143	8.8143	542.53	186.06	108.51
44394	Colonoscopy w/snare		T	0143	8.8143	542.53	186.06	108.51
44397	Colonoscopy w/stent		T	0384	22.6777	1,395.84	292.31	279.17
44500	Intro, gastrointestinal tube		T	0121	2.3431	144.22	43.80	28.84
44701	Intraop colon lavage add-on		N					
44799	Unlisted procedure intestine	CH	T	0153	22.1758	1,364.94	397.95	272.99
44901	Drain app abscess, percut		T	0037	10.2616	631.61	228.76	126.32
44970	Laparoscopy, appendectomy		T	0131	43.5124	2,678.23	1,001.89	535.65
44979	Laparoscope proc, app		T	0130	31.9353	1,965.65	659.53	393.13
45000	Drainage of pelvic abscess		T	0148	4.8970	301.42		60.28
45005	Drainage of rectal abscess		T	0155	12.8778	792.64		158.53
45020	Drainage of rectal abscess		T	0155	12.8778	792.64		158.53

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45100	Biopsy of rectum		T	0149	22.2336	1,368.50	293.06	273.70
45108	Removal of anorectal lesion	CH	T	0149	22.2336	1,368.50	293.06	273.70
45150	Excision of rectal stricture		T	0149	22.2336	1,368.50	293.06	273.70
45160	Excision of rectal lesion	CH	T	0149	22.2336	1,368.50	293.06	273.70
45170	Excision of rectal lesion	CH	T	0149	22.2336	1,368.50	293.06	273.70
45190	Destruction, rectal tumor	CH	T	0149	22.2336	1,368.50	293.06	273.70
45300	Proctosigmoidoscopy dx		T	0146	4.8005	295.48	64.40	59.10
45303	Proctosigmoidoscopy dilate		T	0147	8.5644	527.15		105.43
45305	Proctosigmoidoscopy w/bx		T	0147	8.5644	527.15		105.43
45307	Proctosigmoidoscopy fb		T	0428	20.4902	1,261.19		252.24
45308	Proctosigmoidoscopy removal		T	0147	8.5644	527.15		105.43
45309	Proctosigmoidoscopy removal		T	0147	8.5644	527.15		105.43
45315	Proctosigmoidoscopy removal		T	0147	8.5644	527.15		105.43
45317	Proctosigmoidoscopy bleed		T	0147	8.5644	527.15		105.43
45320	Proctosigmoidoscopy ablate		T	0428	20.4902	1,261.19		252.24
45321	Proctosigmoidoscopy volvul		T	0428	20.4902	1,261.19		252.24
45327	Proctosigmoidoscopy w/stent		T	0384	22.6777	1,395.84	292.31	279.17
45330	Diagnostic sigmoidoscopy		T	0146	4.8005	295.48	64.40	59.10
45331	Sigmoidoscopy and biopsy		T	0146	4.8005	295.48	64.40	59.10
45332	Sigmoidoscopy w/fb removal		T	0146	4.8005	295.48	64.40	59.10
45333	Sigmoidoscopy&polypectomy		T	0147	8.5644	527.15		105.43
45334	Sigmoidoscopy for bleeding		T	0147	8.5644	527.15		105.43
45335	Sigmoidoscopy w/submuc inj		T	0146	4.8005	295.48	64.40	59.10
45337	Sigmoidoscopy&decompress		T	0146	4.8005	295.48	64.40	59.10
45338	Sigmoidoscopy w/tumr remove		T	0147	8.5644	527.15		105.43
45339	Sigmoidoscopy w/ablate tumr		T	0147	8.5644	527.15		105.43
45340	Sig w/balloon dilation		T	0147	8.5644	527.15		105.43
45341	Sigmoidoscopy w/ultrasound		T	0147	8.5644	527.15		105.43
45342	Sigmoidoscopy w/us guide bx		T	0147	8.5644	527.15		105.43
45345	Sigmoidoscopy w/stent		T	0384	22.6777	1,395.84	292.31	279.17
45355	Surgical colonoscopy		T	0143	8.8143	542.53	186.06	108.51
45378	Diagnostic colonoscopy		T	0143	8.8143	542.53	186.06	108.51
45379	Colonoscopy w/fb removal		T	0143	8.8143	542.53	186.06	108.51
45380	Colonoscopy and biopsy		T	0143	8.8143	542.53	186.06	108.51
45381	Colonoscopy, submucous inj		T	0143	8.8143	542.53	186.06	108.51
45382	Colonoscopy/control bleeding		T	0143	8.8143	542.53	186.06	108.51
45383	Lesion removal colonoscopy		T	0143	8.8143	542.53	186.06	108.51
45384	Lesion remove colonoscopy		T	0143	8.8143	542.53	186.06	108.51
45385	Lesion removal colonoscopy		T	0143	8.8143	542.53	186.06	108.51
45386	Colonoscopy dilate stricture		T	0143	8.8143	542.53	186.06	108.51
45387	Colonoscopy w/stent		T	0384	22.6777	1,395.84	292.31	279.17
45391	Colonoscopy w/endoscope us		T	0143	8.8143	542.53	186.06	108.51
45392	Colonoscopy w/endoscopic fnb		T	0143	8.8143	542.53	186.06	108.51
45499	Laparoscope proc, rectum		T	0130	31.9353	1,965.65	659.53	393.13
45500	Repair of rectum		T	0149	22.2336	1,368.50	293.06	273.70
45505	Repair of rectum		T	0150	29.4386	1,811.98	437.12	362.40
45520	Treatment of rectal prolapse		T	0098	1.1035	67.92		13.58
45541	Correct rectal prolapse		T	0150	29.4386	1,811.98	437.12	362.40
45560	Repair of rectocele		T	0150	29.4386	1,811.98	437.12	362.40
45900	Reduction of rectal prolapse		T	0148	4.8970	301.42		60.28
45905	Dilation of anal sphincter		T	0149	22.2336	1,368.50	293.06	273.70
45910	Dilation of rectal narrowing		T	0149	22.2336	1,368.50	293.06	273.70
45915	Remove rectal obstruction		T	0148	4.8970	301.42		60.28
45990	Surg dx exam, anorectal		T	0148	4.8970	301.42		60.28
45999	Rectum surgery procedure		T	0148	4.8970	301.42		60.28
46020	Placement of seton	CH	T	0149	22.2336	1,368.50	293.06	273.70
46030	Removal of rectal marker		T	0148	4.8970	301.42		60.28
46040	Incision of rectal abscess		T	0149	22.2336	1,368.50	293.06	273.70
46045	Incision of rectal abscess	CH	T	0149	22.2336	1,368.50	293.06	273.70
46050	Incision of anal abscess		T	0148	4.8970	301.42		60.28
46060	Incision of rectal abscess	CH	T	0149	22.2336	1,368.50	293.06	273.70
46070	Incision of anal septum		T	0155	12.8778	792.64		158.53
46080	Incision of anal sphincter		T	0149	22.2336	1,368.50	293.06	273.70
46083	Incise external hemorrhoid	CH	T	0164	2.1159	130.24		26.05
46200	Removal of anal fissure	CH	T	0149	22.2336	1,368.50	293.06	273.70
46210	Removal of anal crypt		T	0149	22.2336	1,368.50	293.06	273.70
46211	Removal of anal crypts	CH	T	0149	22.2336	1,368.50	293.06	273.70
46220	Removal of anal tag		T	0149	22.2336	1,368.50	293.06	273.70
46221	Ligation of hemorrhoid(s)		T	0148	4.8970	301.42		60.28
46230	Removal of anal tags		T	0149	22.2336	1,368.50	293.06	273.70

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46250	Hemorrhoidectomy	CH	T	0149	22.2336	1,368.50	293.06	273.70
46255	Hemorrhoidectomy	CH	T	0149	22.2336	1,368.50	293.06	273.70
46257	Remove hemorrhoids&fissure	CH	T	0149	22.2336	1,368.50	293.06	273.70
46258	Remove hemorrhoids&fistula	CH	T	0149	22.2336	1,368.50	293.06	273.70
46260	Hemorrhoidectomy	CH	T	0149	22.2336	1,368.50	293.06	273.70
46261	Remove hemorrhoids&fissure	CH	T	0149	22.2336	1,368.50	293.06	273.70
46262	Remove hemorrhoids&fistula	CH	T	0149	22.2336	1,368.50	293.06	273.70
46270	Removal of anal fistula	CH	T	0149	22.2336	1,368.50	293.06	273.70
46275	Removal of anal fistula	CH	T	0149	22.2336	1,368.50	293.06	273.70
46280	Removal of anal fistula	CH	T	0149	22.2336	1,368.50	293.06	273.70
46285	Removal of anal fistula	CH	T	0149	22.2336	1,368.50	293.06	273.70
46288	Repair anal fistula	CH	T	0149	22.2336	1,368.50	293.06	273.70
46320	Removal of hemorrhoid clot	CH	T	0155	12.8778	792.64		158.53
46500	Injection into hemorrhoid(s)		T	0155	12.8778	792.64		158.53
46505	Chemodenervation anal musc		T	0148	4.8970	301.42		60.28
46600	Diagnostic anoscopy		X	0340	0.6211	38.23		7.65
46604	Anoscopy and dilation		T	0147	8.5644	527.15		105.43
46606	Anoscopy and biopsy		T	0146	4.8005	295.48	64.40	59.10
46608	Anoscopy, remove for body		T	0147	8.5644	527.15		105.43
46610	Anoscopy, remove lesion		T	0428	20.4902	1,261.19		252.24
46611	Anoscopy		T	0147	8.5644	527.15		105.43
46612	Anoscopy, remove lesions		T	0428	20.4902	1,261.19		252.24
46614	Anoscopy, control bleeding		T	0146	4.8005	295.48	64.40	59.10
46615	Anoscopy		T	0428	20.4902	1,261.19		252.24
46700	Repair of anal stricture	CH	T	0149	22.2336	1,368.50	293.06	273.70
46706	Repr of anal fistula w/glue		T	0150	29.4386	1,811.98	437.12	362.40
46750	Repair of anal sphincter	CH	T	0171	37.2425	2,292.31	705.28	458.46
46753	Reconstruction of anus	CH	T	0149	22.2336	1,368.50	293.06	273.70
46754	Removal of suture from anus		T	0149	22.2336	1,368.50	293.06	273.70
46760	Repair of anal sphincter	CH	T	0171	37.2425	2,292.31	705.28	458.46
46761	Repair of anal sphincter	CH	T	0171	37.2425	2,292.31	705.28	458.46
46762	Implant artificial sphincter	CH	T	0171	37.2425	2,292.31	705.28	458.46
46900	Destruction, anal lesion(s)		T	0016	2.6253	161.59	32.68	32.32
46910	Destruction, anal lesion(s)		T	0017	17.7392	1,091.87	227.84	218.37
46916	Cryosurgery, anal lesion(s)		T	0013	1.0876	66.94		13.39
46917	Laser surgery, anal lesions		T	0695	20.5802	1,266.73	266.59	253.35
46922	Excision of anal lesion(s)		T	0695	20.5802	1,266.73	266.59	253.35
46924	Destruction, anal lesion(s)		T	0695	20.5802	1,266.73	266.59	253.35
46934	Destruction of hemorrhoids		T	0155	12.8778	792.64		158.53
46935	Destruction of hemorrhoids		T	0155	12.8778	792.64		158.53
46936	Destruction of hemorrhoids		T	0149	22.2336	1,368.50	293.06	273.70
46937	Cryotherapy of rectal lesion		T	0149	22.2336	1,368.50	293.06	273.70
46938	Cryotherapy of rectal lesion		T	0150	29.4386	1,811.98	437.12	362.40
46940	Treatment of anal fissure		T	0149	22.2336	1,368.50	293.06	273.70
46942	Treatment of anal fissure		T	0148	4.8970	301.42		60.28
46945	Ligation of hemorrhoids		T	0155	12.8778	792.64		158.53
46946	Ligation of hemorrhoids		T	0155	12.8778	792.64		158.53
46947	Hemorrhoidopexy by stapling		T	0150	29.4386	1,811.98	437.12	362.40
46999	Anus surgery procedure		T	0148	4.8970	301.42		60.28
47000	Needle biopsy of liver		T	0685	6.0729	373.79	115.47	74.76
47001	Needle biopsy, liver add-on		N					
47011	Percut drain, liver lesion		T	0037	10.2616	631.61	228.76	126.32
47370	Laparo ablate liver tumor rf		T	0132	70.8854	4,363.07	1,239.22	872.61
47371	Laparo ablate liver cryosurg		T	0131	43.5124	2,678.23	1,001.89	535.65
47379	Laparoscope procedure, liver		T	0130	31.9353	1,965.65	659.53	393.13
47382	Percut ablate liver rf		T	0423	39.0235	2,401.94		480.39
47399	Liver surgery procedure	CH	T	0004	2.0863	128.41		25.68
47490	Incision of gallbladder		T	0152	19.4515	1,197.26		239.45
47500	Injection for liver x-rays		N					
47505	Injection for liver x-rays		N					
47510	Insert catheter, bile duct		T	0152	19.4515	1,197.26		239.45
47511	Insert bile duct drain		T	0152	19.4515	1,197.26		239.45
47525	Change bile duct catheter		T	0427	11.5220	709.19		141.84
47530	Revise/reinsert bile tube		T	0427	11.5220	709.19		141.84
47552	Biliary endoscopy thru skin		T	0152	19.4515	1,197.26		239.45
47553	Biliary endoscopy thru skin		T	0152	19.4515	1,197.26		239.45
47554	Biliary endoscopy thru skin		T	0152	19.4515	1,197.26		239.45
47555	Biliary endoscopy thru skin		T	0152	19.4515	1,197.26		239.45
47556	Biliary endoscopy thru skin		T	0152	19.4515	1,197.26		239.45
47560	Laparoscopy w/cholangio		T	0130	31.9353	1,965.65	659.53	393.13

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
47561	Laparo w/cholangio/biopsy		T	0130	31.9353	1,965.65	659.53	393.13
47562	Laparoscopic cholecystectomy		T	0131	43.5124	2,678.23	1,001.89	535.65
47563	Laparo cholecystectomy/graph		T	0131	43.5124	2,678.23	1,001.89	535.65
47564	Laparo cholecystectomy/explr		T	0131	43.5124	2,678.23	1,001.89	535.65
47579	Laparoscope proc, biliary		T	0130	31.9353	1,965.65	659.53	393.13
47630	Remove bile duct stone		T	0152	19.4515	1,197.26		239.45
47999	Bile tract surgery procedure		T	0152	19.4515	1,197.26		239.45
48102	Needle biopsy, pancreas		T	0685	6.0729	373.79	115.47	74.76
48511	Drain pancreatic pseudocyst		T	0037	10.2616	631.61	228.76	126.32
48999	Pancreas surgery procedure		T	0004	2.0863	128.41		25.68
49021	Drain abdominal abscess		T	0037	10.2616	631.61	228.76	126.32
49041	Drain, percut, abdom abscess		T	0037	10.2616	631.61	228.76	126.32
49061	Drain, percut, retroper absc		T	0037	10.2616	631.61	228.76	126.32
49080	Puncture, peritoneal cavity		T	0070	3.6425	224.20		44.84
49081	Removal of abdominal fluid		T	0070	3.6425	224.20		44.84
49085	Remove abdomen foreign body		T	0153	22.1758	1,364.94	397.95	272.99
49180	Biopsy, abdominal mass		T	0685	6.0729	373.79	115.47	74.76
49200	Removal of abdominal lesion		T	0130	31.9353	1,965.65	659.53	393.13
49250	Excision of umbilicus		T	0153	22.1758	1,364.94	397.95	272.99
49320	Diag laparo separate proc		T	0130	31.9353	1,965.65	659.53	393.13
49321	Laparoscopy, biopsy		T	0130	31.9353	1,965.65	659.53	393.13
49322	Laparoscopy, aspiration		T	0130	31.9353	1,965.65	659.53	393.13
49323	Laparo drain lymphocele		T	0130	31.9353	1,965.65	659.53	393.13
49329	Laparo proc, abdm/per/oment		T	0130	31.9353	1,965.65	659.53	393.13
49400	Air injection into abdomen		N					
49419	Insrt abdom cath for chemotx		T	0115	29.4757	1,814.26	378.68	362.85
49420	Insert abdom drain, temp		T	0652	29.2259	1,798.88		359.78
49421	Insert abdom drain, perm		T	0652	29.2259	1,798.88		359.78
49422	Remove perm cannula/catheter		T	0105	23.4666	1,444.39	370.40	288.88
49423	Exchange drainage catheter		T	0427	11.5220	709.19		141.84
49424	Assess cyst, contrast inject		N					
49426	Revise abdomen-venous shunt		T	0153	22.1758	1,364.94	397.95	272.99
49427	Injection, abdominal shunt		N					
49429	Removal of shunt		T	0105	23.4666	1,444.39	370.40	288.88
49491	Rpr hern preemie reduc		T	0154	29.1491	1,794.16	464.85	358.83
49492	Rpr ing hern premie, blocked		T	0154	29.1491	1,794.16	464.85	358.83
49495	Rpr ing hernia baby, reduc		T	0154	29.1491	1,794.16	464.85	358.83
49496	Rpr ing hernia baby, blocked		T	0154	29.1491	1,794.16	464.85	358.83
49500	Rpr ing hernia, init, reduce		T	0154	29.1491	1,794.16	464.85	358.83
49501	Rpr ing hernia, init blocked		T	0154	29.1491	1,794.16	464.85	358.83
49505	Prp i/hern init reduc >5 yr		T	0154	29.1491	1,794.16	464.85	358.83
49507	Prp i/hern init block >5 yr		T	0154	29.1491	1,794.16	464.85	358.83
49520	Rerepair ing hernia, reduce		T	0154	29.1491	1,794.16	464.85	358.83
49521	Rerepair ing hernia, blocked		T	0154	29.1491	1,794.16	464.85	358.83
49525	Repair ing hernia, sliding		T	0154	29.1491	1,794.16	464.85	358.83
49540	Repair lumbar hernia		T	0154	29.1491	1,794.16	464.85	358.83
49550	Rpr rem hernia, init, reduce		T	0154	29.1491	1,794.16	464.85	358.83
49553	Rpr fem hernia, init blocked		T	0154	29.1491	1,794.16	464.85	358.83
49555	Rerepair fem hernia, reduce		T	0154	29.1491	1,794.16	464.85	358.83
49557	Rerepair fem hernia, blocked		T	0154	29.1491	1,794.16	464.85	358.83
49560	Rpr ventral hern init, reduc		T	0154	29.1491	1,794.16	464.85	358.83
49561	Rpr ventral hern init, block		T	0154	29.1491	1,794.16	464.85	358.83
49565	Rerepair ventrl hern, reduce		T	0154	29.1491	1,794.16	464.85	358.83
49566	Rerepair ventrl hern, block		T	0154	29.1491	1,794.16	464.85	358.83
49568	Hernia repair w/mesh		T	0154	29.1491	1,794.16	464.85	358.83
49570	Rpr epigastric hern, reduce		T	0154	29.1491	1,794.16	464.85	358.83
49572	Rpr epigastric hern, blocked		T	0154	29.1491	1,794.16	464.85	358.83
49580	Rpr umbil hern, reduc < 5 yr		T	0154	29.1491	1,794.16	464.85	358.83
49582	Rpr umbil hern, block < 5 yr		T	0154	29.1491	1,794.16	464.85	358.83
49585	Rpr umbil hern, reduc > 5 yr		T	0154	29.1491	1,794.16	464.85	358.83
49587	Rpr umbil hern, block > 5 yr		T	0154	29.1491	1,794.16	464.85	358.83
49590	Repair spigelian hernia		T	0154	29.1491	1,794.16	464.85	358.83
49600	Repair umbilical lesion		T	0154	29.1491	1,794.16	464.85	358.83
49650	Laparo hernia repair initial		T	0131	43.5124	2,678.23	1,001.89	535.65
49651	Laparo hernia repair recur		T	0131	43.5124	2,678.23	1,001.89	535.65
49659	Laparo proc, hernia repair		T	0130	31.9353	1,965.65	659.53	393.13
49999	Abdomen surgery procedure		T	0153	22.1758	1,364.94	397.95	272.99
50020	Renal abscess, open drain		T	0162	23.8562	1,468.37		293.67
50021	Renal abscess, percut drain		T	0037	10.2616	631.61	228.76	126.32
50080	Removal of kidney stone		T	0429	42.9327	2,642.55		528.51

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50081	Removal of kidney stone		T	0429	42.9327	2,642.55		528.51
50200	Biopsy of kidney		T	0685	6.0729	373.79	115.47	74.76
50382	Change ureter stent, percut		T	0161	19.2766	1,186.49	249.36	237.30
50384	Remove ureter stent, percut		T	0161	19.2766	1,186.49	249.36	237.30
50387	Change ext/int ureter stent		T	0122	7.2859	448.45		89.69
50389	Remove renal tube w/fluoro		T	0156	3.5688	219.66		43.93
50390	Drainage of kidney lesion		T	0685	6.0729	373.79	115.47	74.76
50391	Instll rx agnt into rnal tub	CH	T	0126	1.0844	66.75	16.40	13.35
50392	Insert kidney drain		T	0161	19.2766	1,186.49	249.36	237.30
50393	Insert ureteral tube		T	0161	19.2766	1,186.49	249.36	237.30
50394	Injection for kidney x-ray		N					
50395	Create passage to kidney		T	0161	19.2766	1,186.49	249.36	237.30
50396	Measure kidney pressure		T	0164	2.1159	130.24		26.05
50398	Change kidney tube		T	0122	7.2859	448.45		89.69
50541	Laparo ablate renal cyst		T	0130	31.9353	1,965.65	659.53	393.13
50542	Laparo ablate renal mass		T	0132	70.8854	4,363.07	1,239.22	872.61
50543	Laparo partial nephrectomy		T	0131	43.5124	2,678.23	1,001.89	535.65
50544	Laparoscopy, pyeloplasty		T	0130	31.9353	1,965.65	659.53	393.13
50549	Laparoscope proc, renal		T	0130	31.9353	1,965.65	659.53	393.13
50551	Kidney endoscopy		T	0160	6.7325	414.39	105.06	82.88
50553	Kidney endoscopy		T	0161	19.2766	1,186.49	249.36	237.30
50555	Kidney endoscopy&biopsy		T	0160	6.7325	414.39	105.06	82.88
50557	Kidney endoscopy&treatment		T	0162	23.8562	1,468.37		293.67
50561	Kidney endoscopy&treatment		T	0161	19.2766	1,186.49	249.36	237.30
50562	Renal scope w/tumor resect		T	0160	6.7325	414.39	105.06	82.88
50570	Kidney endoscopy		T	0160	6.7325	414.39	105.06	82.88
50572	Kidney endoscopy		T	0160	6.7325	414.39	105.06	82.88
50574	Kidney endoscopy&biopsy		T	0160	6.7325	414.39	105.06	82.88
50575	Kidney endoscopy		T	0163	35.1024	2,160.59		432.12
50576	Kidney endoscopy&treatment		T	0161	19.2766	1,186.49	249.36	237.30
50590	Fragmenting of kidney stone		T	0169	44.1144	2,715.29	1,009.47	543.06
50592	Perc rf ablate renal tumor		T	0423	39.0235	2,401.94		480.39
50684	Injection for ureter x-ray		N					
50686	Measure ureter pressure	CH	T	0126	1.0844	66.75	16.40	13.35
50688	Change of ureter tube/stent		T	0122	7.2859	448.45		89.69
50690	Injection for ureter x-ray		N					
50945	Laparoscopy ureterolithotomy		T	0131	43.5124	2,678.23	1,001.89	535.65
50947	Laparo new ureter/bladder		T	0131	43.5124	2,678.23	1,001.89	535.65
50948	Laparo new ureter/bladder		T	0131	43.5124	2,678.23	1,001.89	535.65
50949	Laparoscope proc, ureter		T	0130	31.9353	1,965.65	659.53	393.13
50951	Endoscopy of ureter		T	0160	6.7325	414.39	105.06	82.88
50953	Endoscopy of ureter		T	0160	6.7325	414.39	105.06	82.88
50955	Ureter endoscopy&biopsy		T	0161	19.2766	1,186.49	249.36	237.30
50957	Ureter endoscopy&treatment		T	0161	19.2766	1,186.49	249.36	237.30
50961	Ureter endoscopy&treatment		T	0161	19.2766	1,186.49	249.36	237.30
50970	Ureter endoscopy		T	0160	6.7325	414.39	105.06	82.88
50972	Ureter endoscopy&catheter		T	0160	6.7325	414.39	105.06	82.88
50974	Ureter endoscopy&biopsy		T	0161	19.2766	1,186.49	249.36	237.30
50976	Ureter endoscopy&treatment		T	0161	19.2766	1,186.49	249.36	237.30
50980	Ureter endoscopy&treatment		T	0161	19.2766	1,186.49	249.36	237.30
51000	Drainage of bladder		T	0164	2.1159	130.24		26.05
51005	Drainage of bladder	CH	T	0126	1.0844	66.75	16.40	13.35
51010	Drainage of bladder		T	0165	18.2333	1,122.28		224.46
51020	Incise&treat bladder		T	0162	23.8562	1,468.37		293.67
51030	Incise&treat bladder		T	0162	23.8562	1,468.37		293.67
51040	Incise&drain bladder		T	0162	23.8562	1,468.37		293.67
51045	Incise bladder/drain ureter		T	0160	6.7325	414.39	105.06	82.88
51050	Removal of bladder stone		T	0162	23.8562	1,468.37		293.67
51065	Remove ureter calculus		T	0162	23.8562	1,468.37		293.67
51080	Drainage of bladder abscess		T	0008	17.4686	1,075.21		215.04
51500	Removal of bladder cyst		T	0154	29.1491	1,794.16	464.85	358.83
51520	Removal of bladder lesion		T	0162	23.8562	1,468.37		293.67
51600	Injection for bladder x-ray		N					
51605	Preparation for bladder xray		N					
51610	Injection for bladder x-ray		N					
51700	Irrigation of bladder		T	0164	2.1159	130.24		26.05
51701	Insert bladder catheter		X	0340	0.6211	38.23		7.65
51702	Insert temp bladder cath		X	0340	0.6211	38.23		7.65
51703	Insert bladder cath, complex	CH	T	0126	1.0844	66.75	16.40	13.35
51705	Change of bladder tube		T	0121	2.3431	144.22	43.80	28.84

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
51710	Change of bladder tube		T	0122	7.2859	448.45		89.69
51715	Endoscopic injection/implant		T	0168	28.5971	1,760.18	388.16	352.04
51720	Treatment of bladder lesion	CH	T	0164	2.1159	130.24		26.05
51725	Simple cystometrogram	CH	T	0164	2.1159	130.24		26.05
51726	Complex cystometrogram		T	0156	3.5688	219.66		43.93
51736	Urine flow measurement	CH	T	0126	1.0844	66.75	16.40	13.35
51741	Electro-uroflowmetry, first	CH	T	0126	1.0844	66.75	16.40	13.35
51772	Urethra pressure profile	CH	T	0164	2.1159	130.24		26.05
51784	Anal/urinary muscle study	CH	T	0126	1.0844	66.75	16.40	13.35
51785	Anal/urinary muscle study	CH	T	0126	1.0844	66.75	16.40	13.35
51792	Urinary reflex study	CH	T	0126	1.0844	66.75	16.40	13.35
51795	Urine voiding pressure study		T	0164	2.1159	130.24		26.05
51797	Intraabdominal pressure test		T	0164	2.1159	130.24		26.05
51798	Us urine capacity measure		X	0340	0.6211	38.23		7.65
51880	Repair of bladder opening		T	0162	23.8562	1,468.37		293.67
51990	Laparo urethral suspension		T	0131	43.5124	2,678.23	1,001.89	535.65
51992	Laparo sling operation	CH	T	0131	43.5124	2,678.23	1,001.89	535.65
51999	Laparoscope proc, bladder		T	0130	31.9353	1,965.65	659.53	393.13
52000	Cystoscopy		T	0160	6.7325	414.39	105.06	82.88
52001	Cystoscopy, removal of clots		T	0160	6.7325	414.39	105.06	82.88
52005	Cystoscopy&ureter catheter		T	0161	19.2766	1,186.49	249.36	237.30
52007	Cystoscopy and biopsy		T	0161	19.2766	1,186.49	249.36	237.30
52010	Cystoscopy&duct catheter		T	0160	6.7325	414.39	105.06	82.88
52204	Cystoscopy		T	0161	19.2766	1,186.49	249.36	237.30
52214	Cystoscopy and treatment		T	0162	23.8562	1,468.37		293.67
52224	Cystoscopy and treatment		T	0162	23.8562	1,468.37		293.67
52234	Cystoscopy and treatment		T	0162	23.8562	1,468.37		293.67
52235	Cystoscopy and treatment		T	0162	23.8562	1,468.37		293.67
52240	Cystoscopy and treatment		T	0162	23.8562	1,468.37		293.67
52250	Cystoscopy and radiotracer		T	0162	23.8562	1,468.37		293.67
52260	Cystoscopy and treatment		T	0161	19.2766	1,186.49	249.36	237.30
52265	Cystoscopy and treatment		T	0160	6.7325	414.39	105.06	82.88
52270	Cystoscopy&revise urethra		T	0161	19.2766	1,186.49	249.36	237.30
52275	Cystoscopy&revise urethra		T	0161	19.2766	1,186.49	249.36	237.30
52276	Cystoscopy and treatment		T	0161	19.2766	1,186.49	249.36	237.30
52277	Cystoscopy and treatment		T	0162	23.8562	1,468.37		293.67
52281	Cystoscopy and treatment		T	0161	19.2766	1,186.49	249.36	237.30
52282	Cystoscopy, implant stent		T	0163	35.1024	2,160.59		432.12
52283	Cystoscopy and treatment		T	0161	19.2766	1,186.49	249.36	237.30
52285	Cystoscopy and treatment		T	0161	19.2766	1,186.49	249.36	237.30
52290	Cystoscopy and treatment		T	0161	19.2766	1,186.49	249.36	237.30
52300	Cystoscopy and treatment		T	0161	19.2766	1,186.49	249.36	237.30
52301	Cystoscopy and treatment		T	0161	19.2766	1,186.49	249.36	237.30
52305	Cystoscopy and treatment		T	0161	19.2766	1,186.49	249.36	237.30
52310	Cystoscopy and treatment		T	0160	6.7325	414.39	105.06	82.88
52315	Cystoscopy and treatment		T	0161	19.2766	1,186.49	249.36	237.30
52317	Remove bladder stone		T	0162	23.8562	1,468.37		293.67
52318	Remove bladder stone		T	0162	23.8562	1,468.37		293.67
52320	Cystoscopy and treatment		T	0162	23.8562	1,468.37		293.67
52325	Cystoscopy, stone removal		T	0162	23.8562	1,468.37		293.67
52327	Cystoscopy, inject material		T	0162	23.8562	1,468.37		293.67
52330	Cystoscopy and treatment		T	0162	23.8562	1,468.37		293.67
52332	Cystoscopy and treatment		T	0162	23.8562	1,468.37		293.67
52334	Create passage to kidney		T	0162	23.8562	1,468.37		293.67
52341	Cysto w/ureter stricture tx		T	0162	23.8562	1,468.37		293.67
52342	Cysto w/up stricture tx		T	0162	23.8562	1,468.37		293.67
52343	Cysto w/renal stricture tx		T	0162	23.8562	1,468.37		293.67
52344	Cysto/uretero, stricture tx		T	0162	23.8562	1,468.37		293.67
52345	Cysto/uretero w/up stricture		T	0162	23.8562	1,468.37		293.67
52346	Cystouretero w/renal strict		T	0162	23.8562	1,468.37		293.67
52351	Cystouretero&or pyeloscope		T	0161	19.2766	1,186.49	249.36	237.30
52352	Cystouretero w/stone remove		T	0162	23.8562	1,468.37		293.67
52353	Cystouretero w/lithotripsy		T	0163	35.1024	2,160.59		432.12
52354	Cystouretero w/biopsy		T	0162	23.8562	1,468.37		293.67
52355	Cystouretero w/excise tumor		T	0162	23.8562	1,468.37		293.67
52400	Cystouretero w/congen repr		T	0162	23.8562	1,468.37		293.67
52402	Cystourethro cut ejacul duct		T	0162	23.8562	1,468.37		293.67
52450	Incision of prostate		T	0162	23.8562	1,468.37		293.67
52500	Revision of bladder neck		T	0162	23.8562	1,468.37		293.67
52510	Dilation prostatic urethra		T	0161	19.2766	1,186.49	249.36	237.30

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52601	Prostatectomy (TURP)		T	0163	35.1024	2,160.59		432.12
52606	Control postop bleeding		T	0162	23.8562	1,468.37		293.67
52612	Prostatectomy, first stage		T	0163	35.1024	2,160.59		432.12
52614	Prostatectomy, second stage		T	0163	35.1024	2,160.59		432.12
52620	Remove residual prostate		T	0163	35.1024	2,160.59		432.12
52630	Remove prostate regrowth		T	0163	35.1024	2,160.59		432.12
52640	Relieve bladder contracture		T	0162	23.8562	1,468.37		293.67
52647	Laser surgery of prostate		T	0429	42.9327	2,642.55		528.51
52648	Laser surgery of prostate		T	0429	42.9327	2,642.55		528.51
52700	Drainage of prostate abscess		T	0162	23.8562	1,468.37		293.67
53000	Incision of urethra		T	0166	18.5138	1,139.54		227.91
53010	Incision of urethra		T	0166	18.5138	1,139.54		227.91
53020	Incision of urethra		T	0166	18.5138	1,139.54		227.91
53025	Incision of urethra		T	0166	18.5138	1,139.54		227.91
53040	Drainage of urethra abscess		T	0166	18.5138	1,139.54		227.91
53060	Drainage of urethra abscess		T	0166	18.5138	1,139.54		227.91
53080	Drainage of urinary leakage		T	0166	18.5138	1,139.54		227.91
53085	Drainage of urinary leakage		T	0166	18.5138	1,139.54		227.91
53200	Biopsy of urethra		T	0166	18.5138	1,139.54		227.91
53210	Removal of urethra		T	0168	28.5971	1,760.18	388.16	352.04
53215	Removal of urethra		T	0166	18.5138	1,139.54		227.91
53220	Treatment of urethra lesion		T	0168	28.5971	1,760.18	388.16	352.04
53230	Removal of urethra lesion		T	0168	28.5971	1,760.18	388.16	352.04
53235	Removal of urethra lesion		T	0166	18.5138	1,139.54		227.91
53240	Surgery for urethra pouch		T	0168	28.5971	1,760.18	388.16	352.04
53250	Removal of urethra gland		T	0166	18.5138	1,139.54		227.91
53260	Treatment of urethra lesion		T	0166	18.5138	1,139.54		227.91
53265	Treatment of urethra lesion		T	0166	18.5138	1,139.54		227.91
53270	Removal of urethra gland		T	0166	18.5138	1,139.54		227.91
53275	Repair of urethra defect		T	0166	18.5138	1,139.54		227.91
53400	Revise urethra, stage 1		T	0168	28.5971	1,760.18	388.16	352.04
53405	Revise urethra, stage 2		T	0168	28.5971	1,760.18	388.16	352.04
53410	Reconstruction of urethra		T	0168	28.5971	1,760.18	388.16	352.04
53420	Reconstruct urethra, stage 1		T	0168	28.5971	1,760.18	388.16	352.04
53425	Reconstruct urethra, stage 2		T	0168	28.5971	1,760.18	388.16	352.04
53430	Reconstruction of urethra		T	0168	28.5971	1,760.18	388.16	352.04
53431	Reconstruct urethra/bladder		T	0168	28.5971	1,760.18	388.16	352.04
53440	Male sling procedure		S	0385	79.3730	4,885.49		977.10
53442	Remove/revise male sling		T	0168	28.5971	1,760.18	388.16	352.04
53444	Insert tandem cuff		S	0385	79.3730	4,885.49		977.10
53445	Insert uro/ves nck sphincter		S	0386	135.7295	8,354.29		1,670.86
53446	Remove uro sphincter		T	0168	28.5971	1,760.18	388.16	352.04
53447	Remove/replace ur sphincter		S	0386	135.7295	8,354.29		1,670.86
53449	Repair uro sphincter		T	0168	28.5971	1,760.18	388.16	352.04
53450	Revision of urethra		T	0168	28.5971	1,760.18	388.16	352.04
53460	Revision of urethra		T	0166	18.5138	1,139.54		227.91
53500	Urethrlys, transvag w/scope		T	0168	28.5971	1,760.18	388.16	352.04
53502	Repair of urethra injury		T	0166	18.5138	1,139.54		227.91
53505	Repair of urethra injury		T	0168	28.5971	1,760.18	388.16	352.04
53510	Repair of urethra injury		T	0166	18.5138	1,139.54		227.91
53515	Repair of urethra injury		T	0168	28.5971	1,760.18	388.16	352.04
53520	Repair of urethra defect		T	0168	28.5971	1,760.18	388.16	352.04
53600	Dilate urethra stricture		T	0156	3.5688	219.66		43.93
53601	Dilate urethra stricture	CH	T	0126	1.0844	66.75	16.40	13.35
53605	Dilate urethra stricture		T	0161	19.2766	1,186.49	249.36	237.30
53620	Dilate urethra stricture		T	0165	18.2333	1,122.28		224.46
53621	Dilate urethra stricture		T	0164	2.1159	130.24		26.05
53660	Dilation of urethra	CH	T	0126	1.0844	66.75	16.40	13.35
53661	Dilation of urethra	CH	T	0126	1.0844	66.75	16.40	13.35
53665	Dilation of urethra		T	0166	18.5138	1,139.54		227.91
53850	Prostatic microwave thermotx		T	0675	42.3176	2,604.69		520.94
53852	Prostatic rf thermotx		T	0675	42.3176	2,604.69		520.94
53853	Prostatic water thermother		T	0162	23.8562	1,468.37		293.67
53899	Urology surgery procedure	CH	T	0126	1.0844	66.75	16.40	13.35
54000	Slitting of prepuce		T	0166	18.5138	1,139.54		227.91
54001	Slitting of prepuce		T	0166	18.5138	1,139.54		227.91
54015	Drain penis lesion		T	0008	17.4686	1,075.21		215.04
54050	Destruction, penis lesion(s)		T	0013	1.0876	66.94		13.39
54055	Destruction, penis lesion(s)		T	0017	17.7392	1,091.87	227.84	218.37
54056	Cryosurgery, penis lesion(s)		T	0012	0.8076	49.71	10.30	9.94

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54057	Laser surg, penis lesion(s)		T	0017	17.7392	1,091.87	227.84	218.37
54060	Excision of penis lesion(s)		T	0017	17.7392	1,091.87	227.84	218.37
54065	Destruction, penis lesion(s)		T	0695	20.5802	1,266.73	266.59	253.35
54100	Biopsy of penis		T	0021	14.9563	920.58	219.48	184.12
54105	Biopsy of penis		T	0022	19.9760	1,229.54	354.45	245.91
54110	Treatment of penis lesion		T	0181	32.9991	2,031.13	621.82	406.23
54111	Treat penis lesion, graft		T	0181	32.9991	2,031.13	621.82	406.23
54112	Treat penis lesion, graft		T	0181	32.9991	2,031.13	621.82	406.23
54115	Treatment of penis lesion		T	0008	17.4686	1,075.21		215.04
54120	Partial removal of penis		T	0181	32.9991	2,031.13	621.82	406.23
54150	Circumcision		T	0180	20.7418	1,276.68	304.87	255.34
54152	Circumcision		T	0180	20.7418	1,276.68	304.87	255.34
54160	Circumcision		T	0180	20.7418	1,276.68	304.87	255.34
54161	Circumcision		T	0180	20.7418	1,276.68	304.87	255.34
54162	Lysis penil circumic lesion		T	0180	20.7418	1,276.68	304.87	255.34
54163	Repair of circumcision		T	0180	20.7418	1,276.68	304.87	255.34
54164	Frenulotomy of penis		T	0180	20.7418	1,276.68	304.87	255.34
54200	Treatment of penis lesion	CH	T	0164	2.1159	130.24		26.05
54205	Treatment of penis lesion		T	0181	32.9991	2,031.13	621.82	406.23
54220	Treatment of penis lesion	CH	T	0164	2.1159	130.24		26.05
54230	Prepare penis study		N					
54231	Dynamic cavernosometry		T	0165	18.2333	1,122.28		224.46
54235	Penile injection		T	0164	2.1159	130.24		26.05
54240	Penis study	CH	T	0126	1.0844	66.75	16.40	13.35
54250	Penis study		T	0164	2.1159	130.24		26.05
54300	Revision of penis		T	0181	32.9991	2,031.13	621.82	406.23
54304	Revision of penis		T	0181	32.9991	2,031.13	621.82	406.23
54308	Reconstruction of urethra		T	0181	32.9991	2,031.13	621.82	406.23
54312	Reconstruction of urethra		T	0181	32.9991	2,031.13	621.82	406.23
54316	Reconstruction of urethra		T	0181	32.9991	2,031.13	621.82	406.23
54318	Reconstruction of urethra		T	0181	32.9991	2,031.13	621.82	406.23
54322	Reconstruction of urethra		T	0181	32.9991	2,031.13	621.82	406.23
54324	Reconstruction of urethra		T	0181	32.9991	2,031.13	621.82	406.23
54326	Reconstruction of urethra		T	0181	32.9991	2,031.13	621.82	406.23
54328	Revise penis/urethra		T	0181	32.9991	2,031.13	621.82	406.23
54340	Secondary urethral surgery		T	0181	32.9991	2,031.13	621.82	406.23
54344	Secondary urethral surgery		T	0181	32.9991	2,031.13	621.82	406.23
54348	Secondary urethral surgery		T	0181	32.9991	2,031.13	621.82	406.23
54352	Reconstruct urethra/penis		T	0181	32.9991	2,031.13	621.82	406.23
54360	Penis plastic surgery		T	0181	32.9991	2,031.13	621.82	406.23
54380	Repair penis		T	0181	32.9991	2,031.13	621.82	406.23
54385	Repair penis		T	0181	32.9991	2,031.13	621.82	406.23
54400	Insert semi-rigid prosthesis		S	0385	79.3730	4,885.49		977.10
54401	Insert self-contd prosthesis		S	0386	135.7295	8,354.29		1,670.86
54405	Insert multi-comp penis pros		S	0386	135.7295	8,354.29		1,670.86
54406	Remove muti-comp penis pros		T	0181	32.9991	2,031.13	621.82	406.23
54408	Repair multi-comp penis pros		T	0181	32.9991	2,031.13	621.82	406.23
54410	Remove/replace penis prosth		S	0386	135.7295	8,354.29		1,670.86
54415	Remove self-contd penis pros		T	0181	32.9991	2,031.13	621.82	406.23
54416	Remv/repl penis contain pros		S	0386	135.7295	8,354.29		1,670.86
54420	Revision of penis		T	0181	32.9991	2,031.13	621.82	406.23
54435	Revision of penis		T	0181	32.9991	2,031.13	621.82	406.23
54440	Repair of penis		T	0181	32.9991	2,031.13	621.82	406.23
54450	Preputial stretching		T	0156	3.5688	219.66		43.93
54500	Biopsy of testis		T	0037	10.2616	631.61	228.76	126.32
54505	Biopsy of testis		T	0183	23.7072	1,459.20		291.84
54512	Excise lesion testis		T	0183	23.7072	1,459.20		291.84
54520	Removal of testis		T	0183	23.7072	1,459.20		291.84
54522	Orchiectomy, partial		T	0183	23.7072	1,459.20		291.84
54530	Removal of testis		T	0154	29.1491	1,794.16	464.85	358.83
54550	Exploration for testis		T	0154	29.1491	1,794.16	464.85	358.83
54560	Exploration for testis		T	0183	23.7072	1,459.20		291.84
54600	Reduce testis torsion		T	0183	23.7072	1,459.20		291.84
54620	Suspension of testis		T	0183	23.7072	1,459.20		291.84
54640	Suspension of testis		T	0154	29.1491	1,794.16	464.85	358.83
54660	Revision of testis		T	0183	23.7072	1,459.20		291.84
54670	Repair testis injury		T	0183	23.7072	1,459.20		291.84
54680	Relocation of testis(es)		T	0183	23.7072	1,459.20		291.84
54690	Laparoscopy, orchiectomy		T	0131	43.5124	2,678.23	1,001.89	535.65
54692	Laparoscopy, orchiopexy		T	0132	70.8854	4,363.07	1,239.22	872.61

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54699	Laparoscope proc, testis		T	0130	31.9353	1,965.65	659.53	393.13
54700	Drainage of scrotum		T	0183	23.7072	1,459.20		291.84
54800	Biopsy of epididymis		T	0004	2.0863	128.41		25.68
54820	Exploration of epididymis		T	0183	23.7072	1,459.20		291.84
54830	Remove epididymis lesion		T	0183	23.7072	1,459.20		291.84
54840	Remove epididymis lesion		T	0183	23.7072	1,459.20		291.84
54860	Removal of epididymis		T	0183	23.7072	1,459.20		291.84
54861	Removal of epididymis		T	0183	23.7072	1,459.20		291.84
54900	Fusion of spermatic ducts		T	0183	23.7072	1,459.20		291.84
54901	Fusion of spermatic ducts		T	0183	23.7072	1,459.20		291.84
55000	Drainage of hydrocele		T	0004	2.0863	128.41		25.68
55040	Removal of hydrocele		T	0154	29.1491	1,794.16	464.85	358.83
55041	Removal of hydroceles		T	0154	29.1491	1,794.16	464.85	358.83
55060	Repair of hydrocele		T	0183	23.7072	1,459.20		291.84
55100	Drainage of scrotum abscess	CH	T	0007	10.9184	672.04		134.41
55110	Explore scrotum		T	0183	23.7072	1,459.20		291.84
55120	Removal of scrotum lesion		T	0183	23.7072	1,459.20		291.84
55150	Removal of scrotum		T	0183	23.7072	1,459.20		291.84
55175	Revision of scrotum		T	0183	23.7072	1,459.20		291.84
55180	Revision of scrotum		T	0183	23.7072	1,459.20		291.84
55200	Incision of sperm duct		T	0183	23.7072	1,459.20		291.84
55250	Removal of sperm duct(s)		T	0183	23.7072	1,459.20		291.84
55300	Prepare, sperm duct x-ray		N					
55400	Repair of sperm duct		T	0183	23.7072	1,459.20		291.84
55450	Ligation of sperm duct		T	0183	23.7072	1,459.20		291.84
55500	Removal of hydrocele		T	0183	23.7072	1,459.20		291.84
55520	Removal of sperm cord lesion		T	0183	23.7072	1,459.20		291.84
55530	Revise spermatic cord veins		T	0183	23.7072	1,459.20		291.84
55535	Revise spermatic cord veins		T	0154	29.1491	1,794.16	464.85	358.83
55540	Revise hernia&sperm veins		T	0154	29.1491	1,794.16	464.85	358.83
55550	Laparo ligate spermatic vein		T	0131	43.5124	2,678.23	1,001.89	535.65
55559	Laparo proc, spermatic cord		T	0130	31.9353	1,965.65	659.53	393.13
55600	Incise sperm duct pouch		T	0183	23.7072	1,459.20		291.84
55680	Remove sperm pouch lesion		T	0183	23.7072	1,459.20		291.84
55700	Biopsy of prostate		T	0184	5.9892	368.64	96.27	73.73
55705	Biopsy of prostate		T	0184	5.9892	368.64	96.27	73.73
55720	Drainage of prostate abscess		T	0162	23.8562	1,468.37		293.67
55725	Drainage of prostate abscess		T	0162	23.8562	1,468.37		293.67
55859	Percut/needle insert, pros		T	0163	35.1024	2,160.59		432.12
55860	Surgical exposure, prostate		T	0165	18.2333	1,122.28		224.46
55870	Electroejaculation		T	0197	4.4108	271.49		54.30
55873	Cryoablate prostate		T	0674	107.8298	6,637.03		1,327.41
55899	Genital surgery procedure	CH	T	0126	1.0844	66.75	16.40	13.35
56405	I&D of vulva/perineum		T	0189	2.9902	184.05		36.81
56420	Drainage of gland abscess	CH	T	0188	1.4050	86.48		17.30
56440	Surgery for vulva lesion		T	0194	20.5113	1,262.49	397.84	252.50
56441	Lysis of labial lesion(s)		T	0193	14.7958	910.70		182.14
56501	Destroy, vulva lesions, sim		T	0017	17.7392	1,091.87	227.84	218.37
56515	Destroy vulva lesion/s compl		T	0695	20.5802	1,266.73	266.59	253.35
56605	Biopsy of vulva/perineum		T	0019	4.0123	246.96	71.87	49.39
56606	Biopsy of vulva/perineum		T	0019	4.0123	246.96	71.87	49.39
56620	Partial removal of vulva		T	0195	28.7410	1,769.04	483.80	353.81
56625	Complete removal of vulva		T	0195	28.7410	1,769.04	483.80	353.81
56700	Partial removal of hymen		T	0194	20.5113	1,262.49	397.84	252.50
56720	Incision of hymen		T	0193	14.7958	910.70		182.14
56740	Remove vagina gland lesion		T	0194	20.5113	1,262.49	397.84	252.50
56800	Repair of vagina		T	0194	20.5113	1,262.49	397.84	252.50
56805	Repair clitoris		T	0193	14.7958	910.70		182.14
56810	Repair of perineum		T	0194	20.5113	1,262.49	397.84	252.50
56820	Exam of vulva w/scope		T	0188	1.4050	86.48		17.30
56821	Exam/biopsy of vulva w/scope		T	0189	2.9902	184.05		36.81
57000	Exploration of vagina		T	0193	14.7958	910.70		182.14
57010	Drainage of pelvic abscess		T	0193	14.7958	910.70		182.14
57020	Drainage of pelvic fluid		T	0192	6.9265	426.33		85.27
57022	I&d vaginal hematoma, pp		T	0007	10.9184	672.04		134.41
57023	I&d vag hematoma, non-ob		T	0008	17.4686	1,075.21		215.04
57061	Destroy vag lesions, simple		T	0194	20.5113	1,262.49	397.84	252.50
57065	Destroy vag lesions, complex		T	0194	20.5113	1,262.49	397.84	252.50
57100	Biopsy of vagina		T	0192	6.9265	426.33		85.27
57105	Biopsy of vagina		T	0194	20.5113	1,262.49	397.84	252.50

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57106	Remove vagina wall, partial		T	0194	20.5113	1,262.49	397.84	252.50
57107	Remove vagina tissue, part		T	0195	28.7410	1,769.04	483.80	353.81
57109	Vaginectomy partial w/nodes		T	0195	28.7410	1,769.04	483.80	353.81
57120	Closure of vagina		T	0195	28.7410	1,769.04	483.80	353.81
57130	Remove vagina lesion		T	0194	20.5113	1,262.49	397.84	252.50
57135	Remove vagina lesion		T	0194	20.5113	1,262.49	397.84	252.50
57150	Treat vagina infection		T	0191	0.1501	9.24		1.85
57155	Insert uteri tandems/ovoids		T	0192	6.9265	426.33		85.27
57160	Insert pessary/other device		T	0188	1.4050	86.48		17.30
57170	Fitting of diaphragm/cap		T	0191	0.1501	9.24		1.85
57180	Treat vaginal bleeding		T	0189	2.9902	184.05		36.81
57200	Repair of vagina		T	0194	20.5113	1,262.49	397.84	252.50
57210	Repair vagina/perineum		T	0194	20.5113	1,262.49	397.84	252.50
57220	Revision of urethra		T	0202	42.8756	2,639.04	981.50	527.81
57230	Repair of urethral lesion		T	0195	28.7410	1,769.04	483.80	353.81
57240	Repair bladder&vagina		T	0195	28.7410	1,769.04	483.80	353.81
57250	Repair rectum&vagina		T	0195	28.7410	1,769.04	483.80	353.81
57260	Repair of vagina		T	0195	28.7410	1,769.04	483.80	353.81
57265	Extensive repair of vagina		T	0202	42.8756	2,639.04	981.50	527.81
57267	Insert mesh/pelvic flr addon	CH	T	0195	28.7410	1,769.04	483.80	353.81
57268	Repair of bowel bulge		T	0195	28.7410	1,769.04	483.80	353.81
57284	Repair paravaginal defect		T	0202	42.8756	2,639.04	981.50	527.81
57287	Revise/remove sling repair	CH	T	0195	28.7410	1,769.04	483.80	353.81
57288	Repair bladder defect		T	0202	42.8756	2,639.04	981.50	527.81
57289	Repair bladder&vagina		T	0195	28.7410	1,769.04	483.80	353.81
57291	Construction of vagina		T	0195	28.7410	1,769.04	483.80	353.81
57292	Construct vagina with graft	CH	T	0195	28.7410	1,769.04	483.80	353.81
57295	Change vaginal graft		T	0194	20.5113	1,262.49	397.84	252.50
57300	Repair rectum-vagina fistula		T	0195	28.7410	1,769.04	483.80	353.81
57310	Repair urethrovaginal lesion		T	0202	42.8756	2,639.04	981.50	527.81
57320	Repair bladder-vagina lesion		T	0195	28.7410	1,769.04	483.80	353.81
57330	Repair bladder-vagina lesion		T	0195	28.7410	1,769.04	483.80	353.81
57335	Repair vagina	CH	T	0195	28.7410	1,769.04	483.80	353.81
57400	Dilation of vagina		T	0194	20.5113	1,262.49	397.84	252.50
57410	Pelvic examination		T	0193	14.7958	910.70		182.14
57415	Remove vaginal foreign body		T	0194	20.5113	1,262.49	397.84	252.50
57420	Exam of vagina w/scope		T	0189	2.9902	184.05		36.81
57421	Exam/biopsy of vag w/scope		T	0189	2.9902	184.05		36.81
57425	Laparoscopy, surg, colpopexy		T	0130	31.9353	1,965.65	659.53	393.13
57452	Exam of cervix w/scope	CH	T	0188	1.4050	86.48		17.30
57454	Bx/curett of cervix w/scope		T	0189	2.9902	184.05		36.81
57455	Biopsy of cervix w/scope		T	0189	2.9902	184.05		36.81
57456	Endocerv curettage w/scope		T	0189	2.9902	184.05		36.81
57460	Bx of cervix w/scope, leep		T	0193	14.7958	910.70		182.14
57461	Conz of cervix w/scope, leep		T	0194	20.5113	1,262.49	397.84	252.50
57500	Biopsy of cervix	CH	T	0189	2.9902	184.05		36.81
57505	Endocervical curettage		T	0189	2.9902	184.05		36.81
57510	Cauterization of cervix		T	0193	14.7958	910.70		182.14
57511	Cryocautery of cervix	CH	T	0188	1.4050	86.48		17.30
57513	Laser surgery of cervix		T	0193	14.7958	910.70		182.14
57520	Conization of cervix		T	0194	20.5113	1,262.49	397.84	252.50
57522	Conization of cervix		T	0195	28.7410	1,769.04	483.80	353.81
57530	Removal of cervix		T	0195	28.7410	1,769.04	483.80	353.81
57550	Removal of residual cervix		T	0195	28.7410	1,769.04	483.80	353.81
57555	Remove cervix/repair vagina		T	0195	28.7410	1,769.04	483.80	353.81
57556	Remove cervix, repair bowel		T	0202	42.8756	2,639.04	981.50	527.81
57700	Revision of cervix		T	0194	20.5113	1,262.49	397.84	252.50
57720	Revision of cervix		T	0194	20.5113	1,262.49	397.84	252.50
57800	Dilation of cervical canal		T	0193	14.7958	910.70		182.14
57820	D&c of residual cervix		T	0196	17.7635	1,093.36	338.23	218.67
58100	Biopsy of uterus lining		T	0188	1.4050	86.48		17.30
58110	Bx done w/colposcopy add-on		T	0188	1.4050	86.48		17.30
58120	Dilation and curettage		T	0196	17.7635	1,093.36	338.23	218.67
58145	Myomectomy vag method		T	0195	28.7410	1,769.04	483.80	353.81
58301	Remove intrauterine device	CH	T	0188	1.4050	86.48		17.30
58321	Artificial insemination		T	0197	4.4108	271.49		54.30
58322	Artificial insemination		T	0197	4.4108	271.49		54.30
58323	Sperm washing		T	0197	4.4108	271.49		54.30
58340	Catheter for hysterography		N					
58345	Reopen fallopian tube		T	0193	14.7958	910.70		182.14

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58346	Insert heyman uteri capsule		T	0193	14.7958	910.70		182.14
58350	Reopen fallopian tube		T	0195	28.7410	1,769.04	483.80	353.81
58353	Endometr ablate, thermal		T	0195	28.7410	1,769.04	483.80	353.81
58356	Endometrial cryoablation		T	0202	42.8756	2,639.04	981.50	527.81
58545	Laparoscopic myomectomy		T	0130	31.9353	1,965.65	659.53	393.13
58546	Laparo-myomectomy, complex		T	0131	43.5124	2,678.23	1,001.89	535.65
58550	Laparo-asst vag hysterectomy		T	0132	70.8854	4,363.07	1,239.22	872.61
58552	Laparo-vag hyst incl t/o		T	0131	43.5124	2,678.23	1,001.89	535.65
58553	Laparo-vag hyst, complex		T	0131	43.5124	2,678.23	1,001.89	535.65
58554	Laparo-vag hyst w/t/o, compl		T	0131	43.5124	2,678.23	1,001.89	535.65
58555	Hysteroscopy, dx, sep proc		T	0190	21.4199	1,318.42	424.28	263.68
58558	Hysteroscopy, biopsy		T	0190	21.4199	1,318.42	424.28	263.68
58559	Hysteroscopy, lysis		T	0190	21.4199	1,318.42	424.28	263.68
58560	Hysteroscopy, resect septum		T	0387	33.3029	2,049.83	655.55	409.97
58561	Hysteroscopy, remove myoma		T	0387	33.3029	2,049.83	655.55	409.97
58562	Hysteroscopy, remove fb		T	0190	21.4199	1,318.42	424.28	263.68
58563	Hysteroscopy, ablation		T	0387	33.3029	2,049.83	655.55	409.97
58565	Hysteroscopy, sterilization		T	0202	42.8756	2,639.04	981.50	527.81
58578	Laparo proc, uterus		T	0130	31.9353	1,965.65	659.53	393.13
58579	Hysteroscope procedure		T	0190	21.4199	1,318.42	424.28	263.68
58600	Division of fallopian tube		T	0195	28.7410	1,769.04	483.80	353.81
58615	Occlude fallopian tube(s)		T	0194	20.5113	1,262.49	397.84	252.50
58660	Laparoscopy, lysis		T	0131	43.5124	2,678.23	1,001.89	535.65
58661	Laparoscopy, remove adnexa		T	0131	43.5124	2,678.23	1,001.89	535.65
58662	Laparoscopy, excise lesions		T	0131	43.5124	2,678.23	1,001.89	535.65
58670	Laparoscopy, tubal cautery		T	0131	43.5124	2,678.23	1,001.89	535.65
58671	Laparoscopy, tubal block		T	0131	43.5124	2,678.23	1,001.89	535.65
58672	Laparoscopy, fimbrioplasty		T	0131	43.5124	2,678.23	1,001.89	535.65
58673	Laparoscopy, salpingostomy		T	0131	43.5124	2,678.23	1,001.89	535.65
58679	Laparo proc, oviduct-ovary		T	0130	31.9353	1,965.65	659.53	393.13
58770	Create new tubal opening		T	0195	28.7410	1,769.04	483.80	353.81
58800	Drainage of ovarian cyst(s)		T	0193	14.7958	910.70		182.14
58820	Drain ovary abscess, open		T	0195	28.7410	1,769.04	483.80	353.81
58823	Drain pelvic abscess, percut		T	0193	14.7958	910.70		182.14
58900	Biopsy of ovary(s)		T	0193	14.7958	910.70		182.14
58920	Partial removal of ovary(s)		T	0195	28.7410	1,769.04	483.80	353.81
58925	Removal of ovarian cyst(s)		T	0195	28.7410	1,769.04	483.80	353.81
58970	Retrieval of oocyte		T	0197	4.4108	271.49		54.30
58974	Transfer of embryo		T	0197	4.4108	271.49		54.30
58976	Transfer of embryo		T	0197	4.4108	271.49		54.30
58999	Genital surgery procedure		T	0191	0.1501	9.24		1.85
59000	Amniocentesis, diagnostic		T	0198	1.4026	86.33	32.19	17.27
59001	Amniocentesis, therapeutic		T	0192	6.9265	426.33		85.27
59012	Fetal cord puncture,prenatal		T	0198	1.4026	86.33	32.19	17.27
59015	Chorion biopsy		T	0198	1.4026	86.33	32.19	17.27
59020	Fetal contract stress test	CH	T	0189	2.9902	184.05		36.81
59025	Fetal non-stress test		T	0198	1.4026	86.33	32.19	17.27
59030	Fetal scalp blood sample		T	0198	1.4026	86.33	32.19	17.27
59070	Transabdom amnioinfus w/us		T	0198	1.4026	86.33	32.19	17.27
59072	Umbilical cord occlud w/us		T	0198	1.4026	86.33	32.19	17.27
59074	Fetal fluid drainage w/us		T	0198	1.4026	86.33	32.19	17.27
59076	Fetal shunt placement, w/us		T	0198	1.4026	86.33	32.19	17.27
59100	Remove uterus lesion		T	0195	28.7410	1,769.04	483.80	353.81
59150	Treat ectopic pregnancy		T	0131	43.5124	2,678.23	1,001.89	535.65
59151	Treat ectopic pregnancy		T	0131	43.5124	2,678.23	1,001.89	535.65
59160	D&c after delivery		T	0196	17.7635	1,093.36	338.23	218.67
59200	Insert cervical dilator		T	0189	2.9902	184.05		36.81
59300	Episiotomy or vaginal repair		T	0193	14.7958	910.70		182.14
59320	Revision of cervix		T	0194	20.5113	1,262.49	397.84	252.50
59409	Obstetrical care		T	0194	20.5113	1,262.49	397.84	252.50
59412	Antepartum manipulation		T	0700	2.8011	172.41		34.48
59414	Deliver placenta		T	0193	14.7958	910.70		182.14
59612	Vbac delivery only		T	0194	20.5113	1,262.49	397.84	252.50
59812	Treatment of miscarriage		T	0201	18.5251	1,140.24	329.65	228.05
59820	Care of miscarriage		T	0201	18.5251	1,140.24	329.65	228.05
59821	Treatment of miscarriage		T	0201	18.5251	1,140.24	329.65	228.05
59840	Abortion		T	0200	17.2607	1,062.41	248.39	212.48
59841	Abortion		T	0200	17.2607	1,062.41	248.39	212.48
59866	Abortion (mpr)		T	0198	1.4026	86.33	32.19	17.27
59870	Evacuate mole of uterus		T	0201	18.5251	1,140.24	329.65	228.05

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
59871	Remove cerclage suture		T	0194	20.5113	1,262.49	397.84	252.50
59897	Fetal invas px w/us		T	0198	1.4026	86.33	32.19	17.27
59898	Laparo proc, ob care/deliver		T	0130	31.9353	1,965.65	659.53	393.13
59899	Maternity care procedure		T	0198	1.4026	86.33	32.19	17.27
60000	Drain thyroid/tongue cyst		T	0252	7.7261	475.55	111.84	95.11
60001	Aspirate/inject thyriod cyst		T	0004	2.0863	128.41		25.68
60100	Biopsy of thyroid		T	0004	2.0863	128.41		25.68
60200	Remove thyroid lesion		T	0114	37.1283	2,285.28	461.19	457.06
60210	Partial thyroid excision		T	0114	37.1283	2,285.28	461.19	457.06
60212	Partial thyroid excision		T	0114	37.1283	2,285.28	461.19	457.06
60220	Partial removal of thyroid		T	0114	37.1283	2,285.28	461.19	457.06
60225	Partial removal of thyroid		T	0114	37.1283	2,285.28	461.19	457.06
60240	Removal of thyroid		T	0114	37.1283	2,285.28	461.19	457.06
60252	Removal of thyroid		T	0256	37.7719	2,324.90		464.98
60260	Repeat thyroid surgery		T	0256	37.7719	2,324.90		464.98
60280	Remove thyroid duct lesion		T	0114	37.1283	2,285.28	461.19	457.06
60281	Remove thyroid duct lesion		T	0114	37.1283	2,285.28	461.19	457.06
60500	Explore parathyroid glands		T	0256	37.7719	2,324.90		464.98
60512	Autotransplant parathyroid		T	0022	19.9760	1,229.54	354.45	245.91
60659	Laparo proc, endocrine		T	0130	31.9353	1,965.65	659.53	393.13
60699	Endocrine surgery procedure		T	0114	37.1283	2,285.28	461.19	457.06
61000	Remove cranial cavity fluid		T	0212	3.0383	187.01	65.96	37.40
61001	Remove cranial cavity fluid		T	0212	3.0383	187.01	65.96	37.40
61020	Remove brain cavity fluid		T	0212	3.0383	187.01	65.96	37.40
61026	Injection into brain canal		T	0212	3.0383	187.01	65.96	37.40
61050	Remove brain canal fluid		T	0212	3.0383	187.01	65.96	37.40
61055	Injection into brain canal		T	0212	3.0383	187.01	65.96	37.40
61070	Brain canal shunt procedure		T	0212	3.0383	187.01	65.96	37.40
61215	Insert brain-fluid device		T	0224	45.6712	2,811.11		562.22
61330	Decompress eye socket		T	0256	37.7719	2,324.90		464.98
61334	Explore orbit/remove object		T	0256	37.7719	2,324.90		464.98
61623	Endovasc tempory vessel occl		T	0081	42.8894	2,639.89		527.98
61626	Transcath occlusion, non-cns		T	0081	42.8894	2,639.89		527.98
61720	Incise skull/brain surgery	CH	T	0221	33.3035	2,049.86	463.62	409.97
61790	Treat trigeminal nerve		T	0220	17.7609	1,093.20		218.64
61791	Treat trigeminal tract		T	0206	5.5439	341.23	75.55	68.25
61795	Brain surgery using computer		S	0302	5.5005	338.56	105.94	67.71
61880	Revise/remove neuroelectrode		T	0687	17.1830	1,057.63	423.05	211.53
61885	Insrt/redo neurostim 1 array		S	0039	175.9328	10,828.84		2,165.77
61886	Implant neurostim arrays		T	0315	235.5774	14,500.02		2,900.00
61888	Revise/remove neuroreceiver		T	0688	33.9521	2,089.79	835.91	417.96
62000	Treat skull fracture	CH	T	0254	23.1564	1,425.30	321.35	285.06
62160	Neuroendoscopy add-on		T	0122	7.2859	448.45		89.69
62194	Replace/irrigate catheter		T	0427	11.5220	709.19		141.84
62225	Replace/irrigate catheter		T	0427	11.5220	709.19		141.84
62230	Replace/revise brain shunt		T	0224	45.6712	2,811.11		562.22
62252	Csf shunt reprogram		S	0691	2.8253	173.90	60.61	34.78
62263	Epidural lysis mult sessions		T	0203	12.4432	765.89	240.33	153.18
62264	Epidural lysis on single day		T	0203	12.4432	765.89	240.33	153.18
62268	Drain spinal cord cyst		T	0212	3.0383	187.01	65.96	37.40
62269	Needle biopsy, spinal cord		T	0685	6.0729	373.79	115.47	74.76
62270	Spinal fluid tap, diagnostic		T	0204	2.2491	138.43	40.13	27.69
62272	Drain cerebro spinal fluid		T	0204	2.2491	138.43	40.13	27.69
62273	Inject epidural patch		T	0206	5.5439	341.23	75.55	68.25
62280	Treat spinal cord lesion		T	0207	6.3788	392.62	86.92	78.52
62281	Treat spinal cord lesion		T	0207	6.3788	392.62	86.92	78.52
62282	Treat spinal canal lesion		T	0207	6.3788	392.62	86.92	78.52
62284	Injection for myelogram		N					
62287	Percutaneous diskectomy		T	0221	33.3035	2,049.86	463.62	409.97
62290	Inject for spine disk x-ray		N					
62291	Inject for spine disk x-ray		N					
62292	Injection into disk lesion		T	0212	3.0383	187.01	65.96	37.40
62294	Injection into spinal artery		T	0212	3.0383	187.01	65.96	37.40
62310	Inject spine c/t		T	0207	6.3788	392.62	86.92	78.52
62311	Inject spine l/s (cd)		T	0207	6.3788	392.62	86.92	78.52
62318	Inject spine w/cath, c/t		T	0207	6.3788	392.62	86.92	78.52
62319	Inject spine w/cath l/s (cd)		T	0207	6.3788	392.62	86.92	78.52
62350	Implant spinal canal cath		T	0223	29.2931	1,803.02		360.60
62351	Implant spinal canal cath		T	0208	43.9030	2,702.27		540.45
62355	Remove spinal canal catheter		T	0203	12.4432	765.89	240.33	153.18

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
62360	Insert spine infusion device		T	0226	112.0147	6,894.62		1,378.92
62361	Implant spine infusion pump		T	0227	183.1974	11,275.98		2,255.20
62362	Implant spine infusion pump		T	0227	183.1974	11,275.98		2,255.20
62365	Remove spine infusion device		T	0221	33.3035	2,049.86	463.62	409.97
62367	Analyze spine infusion pump		S	0691	2.8253	173.90	60.61	34.78
62368	Analyze spine infusion pump		S	0691	2.8253	173.90	60.61	34.78
63001	Removal of spinal lamina		T	0208	43.9030	2,702.27		540.45
63003	Removal of spinal lamina		T	0208	43.9030	2,702.27		540.45
63005	Removal of spinal lamina		T	0208	43.9030	2,702.27		540.45
63011	Removal of spinal lamina		T	0208	43.9030	2,702.27		540.45
63012	Removal of spinal lamina		T	0208	43.9030	2,702.27		540.45
63015	Removal of spinal lamina		T	0208	43.9030	2,702.27		540.45
63016	Removal of spinal lamina		T	0208	43.9030	2,702.27		540.45
63017	Removal of spinal lamina		T	0208	43.9030	2,702.27		540.45
63020	Neck spine disk surgery		T	0208	43.9030	2,702.27		540.45
63030	Low back disk surgery		T	0208	43.9030	2,702.27		540.45
63035	Spinal disk surgery add-on		T	0208	43.9030	2,702.27		540.45
63040	Laminotomy, single cervical		T	0208	43.9030	2,702.27		540.45
63042	Laminotomy, single lumbar		T	0208	43.9030	2,702.27		540.45
63045	Removal of spinal lamina		T	0208	43.9030	2,702.27		540.45
63046	Removal of spinal lamina		T	0208	43.9030	2,702.27		540.45
63047	Removal of spinal lamina		T	0208	43.9030	2,702.27		540.45
63048	Remove spinal lamina add-on		T	0208	43.9030	2,702.27		540.45
63055	Decompress spinal cord		T	0208	43.9030	2,702.27		540.45
63056	Decompress spinal cord		T	0208	43.9030	2,702.27		540.45
63057	Decompress spine cord add-on		T	0208	43.9030	2,702.27		540.45
63064	Decompress spinal cord		T	0208	43.9030	2,702.27		540.45
63066	Decompress spine cord add-on		T	0208	43.9030	2,702.27		540.45
63075	Neck spine disk surgery		T	0208	43.9030	2,702.27		540.45
63600	Remove spinal cord lesion		T	0220	17.7609	1,093.20		218.64
63610	Stimulation of spinal cord		T	0220	17.7609	1,093.20		218.64
63615	Remove lesion of spinal cord		T	0220	17.7609	1,093.20		218.64
63650	Implant neuroelectrodes		S	0040	56.3855	3,470.58		694.12
63655	Implant neuroelectrodes		S	0061	84.2373	5,184.89		1,036.98
63660	Revise/remove neuroelectrode		T	0687	17.1830	1,057.63	423.05	211.53
63685	Insrt/redo spine n generator		T	0222	178.1307	10,964.12		2,192.82
63688	Revise/remove neuroreceiver		T	0688	33.9521	2,089.79	835.91	417.96
63741	Install spinal shunt		T	0228	36.1603	2,225.70		445.14
63744	Revision of spinal shunt		T	0228	36.1603	2,225.70		445.14
63746	Removal of spinal shunt		T	0109	10.9541	674.24		134.85
64400	N block inj, trigeminal		T	0204	2.2491	138.43	40.13	27.69
64402	N block inj, facial		T	0204	2.2491	138.43	40.13	27.69
64405	N block inj, occipital		T	0204	2.2491	138.43	40.13	27.69
64408	N block inj, vagus		T	0204	2.2491	138.43	40.13	27.69
64410	N block inj, phrenic		T	0206	5.5439	341.23	75.55	68.25
64412	N block inj, spinal accessor		T	0206	5.5439	341.23	75.55	68.25
64413	N block inj, cervical plexus		T	0204	2.2491	138.43	40.13	27.69
64415	N block inj, brachial plexus		T	0204	2.2491	138.43	40.13	27.69
64416	N block cont infuse, b plex		T	0204	2.2491	138.43	40.13	27.69
64417	N block inj, axillary		T	0204	2.2491	138.43	40.13	27.69
64418	N block inj, suprascapular		T	0204	2.2491	138.43	40.13	27.69
64420	N block inj, intercost, sng		T	0204	2.2491	138.43	40.13	27.69
64421	N block inj, intercost, mlt		T	0206	5.5439	341.23	75.55	68.25
64425	N block inj, ilio-ing/hypogi		T	0204	2.2491	138.43	40.13	27.69
64430	N block inj, pudendal		T	0204	2.2491	138.43	40.13	27.69
64435	N block inj, paracervical		T	0204	2.2491	138.43	40.13	27.69
64445	N block inj, sciatic, sng		T	0204	2.2491	138.43	40.13	27.69
64446	N blk inj, sciatic, cont inf		T	0206	5.5439	341.23	75.55	68.25
64447	N block inj fem, single		T	0204	2.2491	138.43	40.13	27.69
64448	N block inj fem, cont inf		T	0204	2.2491	138.43	40.13	27.69
64449	N block inj, lumbar plexus		T	0204	2.2491	138.43	40.13	27.69
64450	N block, other peripheral		T	0204	2.2491	138.43	40.13	27.69
64470	Inj paravertebral c/t		T	0207	6.3788	392.62	86.92	78.52
64472	Inj paravertebral c/t add-on		T	0206	5.5439	341.23	75.55	68.25
64475	Inj paravertebral l/s		T	0207	6.3788	392.62	86.92	78.52
64476	Inj paravertebral l/s add-on		T	0206	5.5439	341.23	75.55	68.25
64479	Inj foramen epidural c/t		T	0207	6.3788	392.62	86.92	78.52
64480	Inj foramen epidural add-on		T	0207	6.3788	392.62	86.92	78.52
64483	Inj foramen epidural l/s		T	0207	6.3788	392.62	86.92	78.52
64484	Inj foramen epidural add-on		T	0207	6.3788	392.62	86.92	78.52

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64505	N block, spenopalatine gangl		T	0204	2.2491	138.43	40.13	27.69
64508	N block, carotid sinus s/p		T	0204	2.2491	138.43	40.13	27.69
64510	N block, stellate ganglion		T	0207	6.3788	392.62	86.92	78.52
64517	N block inj, hypogas plxs		T	0204	2.2491	138.43	40.13	27.69
64520	N block, lumbar/thoracic		T	0207	6.3788	392.62	86.92	78.52
64530	N block inj, celiac pelus		T	0207	6.3788	392.62	86.92	78.52
64553	Implant neuroelectrodes		S	0225	234.1628	14,412.95		2,882.59
64555	Implant neuroelectrodes		S	0040	56.3855	3,470.58		694.12
64560	Implant neuroelectrodes		S	0040	56.3855	3,470.58		694.12
64561	Implant neuroelectrodes		S	0040	56.3855	3,470.58		694.12
64565	Implant neuroelectrodes		S	0040	56.3855	3,470.58		694.12
64573	Implant neuroelectrodes		S	0225	234.1628	14,412.95		2,882.59
64575	Implant neuroelectrodes		S	0061	84.2373	5,184.89		1,036.98
64577	Implant neuroelectrodes		S	0061	84.2373	5,184.89		1,036.98
64580	Implant neuroelectrodes		S	0061	84.2373	5,184.89		1,036.98
64581	Implant neuroelectrodes		S	0061	84.2373	5,184.89		1,036.98
64585	Revise/remove neuroelectrode		T	0687	17.1830	1,057.63	423.05	211.53
64590	Insrt/redo perph n generator		T	0222	178.1307	10,964.12		2,192.82
64595	Revise/remove neuroreceiver		T	0688	33.9521	2,089.79	835.91	417.96
64600	Injection treatment of nerve		T	0203	12.4432	765.89	240.33	153.18
64605	Injection treatment of nerve		T	0203	12.4432	765.89	240.33	153.18
64610	Injection treatment of nerve		T	0203	12.4432	765.89	240.33	153.18
64612	Destroy nerve, face muscle		T	0204	2.2491	138.43	40.13	27.69
64613	Destroy nerve, neck muscle		T	0204	2.2491	138.43	40.13	27.69
64614	Destroy nerve, extrem musc		T	0204	2.2491	138.43	40.13	27.69
64620	Injection treatment of nerve		T	0203	12.4432	765.89	240.33	153.18
64622	Destr paravertebrl nerve l/s		T	0203	12.4432	765.89	240.33	153.18
64623	Destr paravertebral n add-on		T	0207	6.3788	392.62	86.92	78.52
64626	Destr paravertebrl nerve c/t		T	0203	12.4432	765.89	240.33	153.18
64627	Destr paravertebral n add-on		T	0207	6.3788	392.62	86.92	78.52
64630	Injection treatment of nerve		T	0206	5.5439	341.23	75.55	68.25
64640	Injection treatment of nerve		T	0206	5.5439	341.23	75.55	68.25
64650	Chemodenerv eccrine glands		T	0204	2.2491	138.43	40.13	27.69
64653	Chemodenerv eccrine glands		T	0204	2.2491	138.43	40.13	27.69
64680	Injection treatment of nerve		T	0207	6.3788	392.62	86.92	78.52
64681	Injection treatment of nerve		T	0203	12.4432	765.89	240.33	153.18
64702	Revise finger/toe nerve		T	0220	17.7609	1,093.20		218.64
64704	Revise hand/foot nerve		T	0220	17.7609	1,093.20		218.64
64708	Revise arm/leg nerve		T	0220	17.7609	1,093.20		218.64
64712	Revision of sciatic nerve		T	0220	17.7609	1,093.20		218.64
64713	Revision of arm nerve(s)		T	0220	17.7609	1,093.20		218.64
64714	Revise low back nerve(s)		T	0220	17.7609	1,093.20		218.64
64716	Revision of cranial nerve		T	0220	17.7609	1,093.20		218.64
64718	Revise ulnar nerve at elbow		T	0220	17.7609	1,093.20		218.64
64719	Revise ulnar nerve at wrist		T	0220	17.7609	1,093.20		218.64
64721	Carpal tunnel surgery		T	0220	17.7609	1,093.20		218.64
64722	Relieve pressure on nerve(s)		T	0220	17.7609	1,093.20		218.64
64726	Release foot/toe nerve		T	0220	17.7609	1,093.20		218.64
64727	Internal nerve revision		T	0220	17.7609	1,093.20		218.64
64732	Incision of brow nerve		T	0220	17.7609	1,093.20		218.64
64734	Incision of cheek nerve		T	0220	17.7609	1,093.20		218.64
64736	Incision of chin nerve		T	0220	17.7609	1,093.20		218.64
64738	Incision of jaw nerve		T	0220	17.7609	1,093.20		218.64
64740	Incision of tongue nerve		T	0220	17.7609	1,093.20		218.64
64742	Incision of facial nerve		T	0220	17.7609	1,093.20		218.64
64744	Incise nerve, back of head		T	0220	17.7609	1,093.20		218.64
64746	Incise diaphragm nerve		T	0220	17.7609	1,093.20		218.64
64761	Incision of pelvis nerve		T	0220	17.7609	1,093.20		218.64
64763	Incise hip/thigh nerve		T	0220	17.7609	1,093.20		218.64
64766	Incise hip/thigh nerve		T	0221	33.3035	2,049.86	463.62	409.97
64771	Sever cranial nerve		T	0220	17.7609	1,093.20		218.64
64772	Incision of spinal nerve		T	0220	17.7609	1,093.20		218.64
64774	Remove skin nerve lesion		T	0220	17.7609	1,093.20		218.64
64776	Remove digit nerve lesion		T	0220	17.7609	1,093.20		218.64
64778	Digit nerve surgery add-on		T	0220	17.7609	1,093.20		218.64
64782	Remove limb nerve lesion		T	0220	17.7609	1,093.20		218.64
64783	Limb nerve surgery add-on		T	0220	17.7609	1,093.20		218.64
64784	Remove nerve lesion		T	0220	17.7609	1,093.20		218.64
64786	Remove sciatic nerve lesion		T	0221	33.3035	2,049.86	463.62	409.97
64787	Implant nerve end		T	0220	17.7609	1,093.20		218.64

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64788	Remove skin nerve lesion		T	0220	17.7609	1,093.20		218.64
64790	Removal of nerve lesion		T	0220	17.7609	1,093.20		218.64
64792	Removal of nerve lesion		T	0221	33.3035	2,049.86	463.62	409.97
64795	Biopsy of nerve		T	0220	17.7609	1,093.20		218.64
64802	Remove sympathetic nerves		T	0220	17.7609	1,093.20		218.64
64804	Remove sympathetic nerves	CH	T	0220	17.7609	1,093.20		218.64
64820	Remove sympathetic nerves		T	0220	17.7609	1,093.20		218.64
64821	Remove sympathetic nerves		T	0054	25.8425	1,590.63		318.13
64822	Remove sympathetic nerves		T	0054	25.8425	1,590.63		318.13
64823	Remove sympathetic nerves		T	0054	25.8425	1,590.63		318.13
64831	Repair of digit nerve		T	0221	33.3035	2,049.86	463.62	409.97
64832	Repair nerve add-on		T	0221	33.3035	2,049.86	463.62	409.97
64834	Repair of hand or foot nerve		T	0221	33.3035	2,049.86	463.62	409.97
64835	Repair of hand or foot nerve		T	0221	33.3035	2,049.86	463.62	409.97
64836	Repair of hand or foot nerve		T	0221	33.3035	2,049.86	463.62	409.97
64837	Repair nerve add-on		T	0221	33.3035	2,049.86	463.62	409.97
64840	Repair of leg nerve		T	0221	33.3035	2,049.86	463.62	409.97
64856	Repair/transpose nerve		T	0221	33.3035	2,049.86	463.62	409.97
64857	Repair arm/leg nerve		T	0221	33.3035	2,049.86	463.62	409.97
64858	Repair sciatic nerve		T	0221	33.3035	2,049.86	463.62	409.97
64859	Nerve surgery		T	0221	33.3035	2,049.86	463.62	409.97
64861	Repair of arm nerves		T	0221	33.3035	2,049.86	463.62	409.97
64862	Repair of low back nerves		T	0221	33.3035	2,049.86	463.62	409.97
64864	Repair of facial nerve		T	0221	33.3035	2,049.86	463.62	409.97
64865	Repair of facial nerve		T	0221	33.3035	2,049.86	463.62	409.97
64870	Fusion of facial/other nerve		T	0221	33.3035	2,049.86	463.62	409.97
64872	Subsequent repair of nerve		T	0221	33.3035	2,049.86	463.62	409.97
64874	Repair&revise nerve add-on		T	0221	33.3035	2,049.86	463.62	409.97
64876	Repair nerve/shorten bone		T	0221	33.3035	2,049.86	463.62	409.97
64885	Nerve graft, head or neck		T	0221	33.3035	2,049.86	463.62	409.97
64886	Nerve graft, head or neck		T	0221	33.3035	2,049.86	463.62	409.97
64890	Nerve graft, hand or foot		T	0221	33.3035	2,049.86	463.62	409.97
64891	Nerve graft, hand or foot		T	0221	33.3035	2,049.86	463.62	409.97
64892	Nerve graft, arm or leg		T	0221	33.3035	2,049.86	463.62	409.97
64893	Nerve graft, arm or leg		T	0221	33.3035	2,049.86	463.62	409.97
64895	Nerve graft, hand or foot		T	0221	33.3035	2,049.86	463.62	409.97
64896	Nerve graft, hand or foot		T	0221	33.3035	2,049.86	463.62	409.97
64897	Nerve graft, arm or leg		T	0221	33.3035	2,049.86	463.62	409.97
64898	Nerve graft, arm or leg		T	0221	33.3035	2,049.86	463.62	409.97
64901	Nerve graft add-on		T	0221	33.3035	2,049.86	463.62	409.97
64902	Nerve graft add-on		T	0221	33.3035	2,049.86	463.62	409.97
64905	Nerve pedicle transfer		T	0221	33.3035	2,049.86	463.62	409.97
64907	Nerve pedicle transfer		T	0221	33.3035	2,049.86	463.62	409.97
64999	Nervous system surgery		T	0204	2.2491	138.43	40.13	27.69
65091	Revise eye		T	0242	35.5217	2,186.40	597.36	437.28
65093	Revise eye with implant	CH	T	0242	35.5217	2,186.40	597.36	437.28
65101	Removal of eye		T	0242	35.5217	2,186.40	597.36	437.28
65103	Remove eye/insert implant		T	0242	35.5217	2,186.40	597.36	437.28
65105	Remove eye/attach implant		T	0242	35.5217	2,186.40	597.36	437.28
65110	Removal of eye		T	0242	35.5217	2,186.40	597.36	437.28
65112	Remove eye/revise socket		T	0242	35.5217	2,186.40	597.36	437.28
65114	Remove eye/revise socket		T	0242	35.5217	2,186.40	597.36	437.28
65125	Revise ocular implant		T	0240	17.0126	1,047.14	307.90	209.43
65130	Insert ocular implant		T	0241	24.8502	1,529.55	384.47	305.91
65135	Insert ocular implant		T	0241	24.8502	1,529.55	384.47	305.91
65140	Attach ocular implant		T	0242	35.5217	2,186.40	597.36	437.28
65150	Revise ocular implant		T	0241	24.8502	1,529.55	384.47	305.91
65155	Reinsert ocular implant		T	0242	35.5217	2,186.40	597.36	437.28
65175	Removal of ocular implant		T	0240	17.0126	1,047.14	307.90	209.43
65205	Remove foreign body from eye		S	0698	1.2244	75.36	16.52	15.07
65210	Remove foreign body from eye		S	0698	1.2244	75.36	16.52	15.07
65220	Remove foreign body from eye		S	0698	1.2244	75.36	16.52	15.07
65222	Remove foreign body from eye		S	0698	1.2244	75.36	16.52	15.07
65235	Remove foreign body from eye		T	0233	14.9969	923.07	266.33	184.61
65260	Remove foreign body from eye		T	0236	16.3433	1,005.95		201.19
65265	Remove foreign body from eye		T	0237	26.9305	1,657.60		331.52
65270	Repair of eye wound		T	0240	17.0126	1,047.14	307.90	209.43
65272	Repair of eye wound		T	0234	22.9479	1,412.47	511.31	282.49
65275	Repair of eye wound		T	0234	22.9479	1,412.47	511.31	282.49
65280	Repair of eye wound		T	0236	16.3433	1,005.95		201.19

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65285	Repair of eye wound		T	0672	36.8820	2,270.12		454.02
65286	Repair of eye wound		T	0232	5.9800	368.07	92.21	73.61
65290	Repair of eye socket wound		T	0243	21.2885	1,310.33	431.09	262.07
65400	Removal of eye lesion		T	0233	14.9969	923.07	266.33	184.61
65410	Biopsy of cornea		T	0233	14.9969	923.07	266.33	184.61
65420	Removal of eye lesion		T	0233	14.9969	923.07	266.33	184.61
65426	Removal of eye lesion		T	0234	22.9479	1,412.47	511.31	282.49
65430	Corneal smear		S	0698	1.2244	75.36	16.52	15.07
65435	Curette/treat cornea		T	0239	6.9354	426.88		85.38
65436	Curette/treat cornea		T	0233	14.9969	923.07	266.33	184.61
65450	Treatment of corneal lesion		S	0231	2.1934	135.01		27.00
65600	Revision of cornea		T	0240	17.0126	1,047.14	307.90	209.43
65710	Corneal transplant		T	0244	37.9446	2,335.53	803.26	467.11
65730	Corneal transplant		T	0244	37.9446	2,335.53	803.26	467.11
65750	Corneal transplant		T	0244	37.9446	2,335.53	803.26	467.11
65755	Corneal transplant		T	0244	37.9446	2,335.53	803.26	467.11
65770	Revise cornea with implant	CH	T	0293	50.6347	3,116.62	1,100.34	623.32
65772	Correction of astigmatism		T	0233	14.9969	923.07	266.33	184.61
65775	Correction of astigmatism		T	0233	14.9969	923.07	266.33	184.61
65780	Ocular reconst, transplant		T	0244	37.9446	2,335.53	803.26	467.11
65781	Ocular reconst, transplant		T	0244	37.9446	2,335.53	803.26	467.11
65782	Ocular reconst, transplant		T	0244	37.9446	2,335.53	803.26	467.11
65800	Drainage of eye		T	0233	14.9969	923.07	266.33	184.61
65805	Drainage of eye		T	0233	14.9969	923.07	266.33	184.61
65810	Drainage of eye		T	0234	22.9479	1,412.47	511.31	282.49
65815	Drainage of eye		T	0234	22.9479	1,412.47	511.31	282.49
65820	Relieve inner eye pressure		T	0232	5.9800	368.07	92.21	73.61
65850	Incision of eye		T	0234	22.9479	1,412.47	511.31	282.49
65855	Laser surgery of eye		T	0247	5.1266	315.55	104.31	63.11
65860	Incise inner eye adhesions		T	0247	5.1266	315.55	104.31	63.11
65865	Incise inner eye adhesions		T	0233	14.9969	923.07	266.33	184.61
65870	Incise inner eye adhesions		T	0234	22.9479	1,412.47	511.31	282.49
65875	Incise inner eye adhesions		T	0234	22.9479	1,412.47	511.31	282.49
65880	Incise inner eye adhesions		T	0233	14.9969	923.07	266.33	184.61
65900	Remove eye lesion		T	0233	14.9969	923.07	266.33	184.61
65920	Remove implant of eye		T	0234	22.9479	1,412.47	511.31	282.49
65930	Remove blood clot from eye		T	0234	22.9479	1,412.47	511.31	282.49
66020	Injection treatment of eye		T	0233	14.9969	923.07	266.33	184.61
66030	Injection treatment of eye		T	0232	5.9800	368.07	92.21	73.61
66130	Remove eye lesion		T	0234	22.9479	1,412.47	511.31	282.49
66150	Glaucoma surgery		T	0234	22.9479	1,412.47	511.31	282.49
66155	Glaucoma surgery		T	0234	22.9479	1,412.47	511.31	282.49
66160	Glaucoma surgery		T	0234	22.9479	1,412.47	511.31	282.49
66165	Glaucoma surgery		T	0234	22.9479	1,412.47	511.31	282.49
66170	Glaucoma surgery		T	0234	22.9479	1,412.47	511.31	282.49
66172	Incision of eye	CH	T	0234	22.9479	1,412.47	511.31	282.49
66180	Implant eye shunt		T	0673	37.3057	2,296.20	649.56	459.24
66185	Revise eye shunt		T	0673	37.3057	2,296.20	649.56	459.24
66220	Repair eye lesion		T	0672	36.8820	2,270.12		454.02
66225	Repair/graft eye lesion		T	0673	37.3057	2,296.20	649.56	459.24
66250	Follow-up surgery of eye		T	0233	14.9969	923.07	266.33	184.61
66500	Incision of iris		T	0232	5.9800	368.07	92.21	73.61
66505	Incision of iris		T	0232	5.9800	368.07	92.21	73.61
66600	Remove iris and lesion		T	0234	22.9479	1,412.47	511.31	282.49
66605	Removal of iris		T	0234	22.9479	1,412.47	511.31	282.49
66625	Removal of iris		T	0232	5.9800	368.07	92.21	73.61
66630	Removal of iris		T	0234	22.9479	1,412.47	511.31	282.49
66635	Removal of iris		T	0234	22.9479	1,412.47	511.31	282.49
66680	Repair iris&ciliary body		T	0234	22.9479	1,412.47	511.31	282.49
66682	Repair iris&ciliary body		T	0234	22.9479	1,412.47	511.31	282.49
66700	Destruction, ciliary body		T	0233	14.9969	923.07	266.33	184.61
66710	Ciliary transsleral therapy		T	0233	14.9969	923.07	266.33	184.61
66711	Ciliary endoscopic ablation		T	0233	14.9969	923.07	266.33	184.61
66720	Destruction, ciliary body		T	0233	14.9969	923.07	266.33	184.61
66740	Destruction, ciliary body		T	0234	22.9479	1,412.47	511.31	282.49
66761	Revision of iris		T	0247	5.1266	315.55	104.31	63.11
66762	Revision of iris		T	0247	5.1266	315.55	104.31	63.11
66770	Removal of inner eye lesion		T	0247	5.1266	315.55	104.31	63.11
66820	Incision, secondary cataract		T	0232	5.9800	368.07	92.21	73.61
66821	After cataract laser surgery		T	0247	5.1266	315.55	104.31	63.11

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
66825	Reposition intraocular lens		T	0234	22.9479	1,412.47	511.31	282.49
66830	Removal of lens lesion		T	0232	5.9800	368.07	92.21	73.61
66840	Removal of lens material		T	0245	14.5427	895.12	217.05	179.02
66850	Removal of lens material		T	0249	28.5043	1,754.47	524.67	350.89
66852	Removal of lens material		T	0249	28.5043	1,754.47	524.67	350.89
66920	Extraction of lens		T	0249	28.5043	1,754.47	524.67	350.89
66930	Extraction of lens		T	0249	28.5043	1,754.47	524.67	350.89
66940	Extraction of lens		T	0245	14.5427	895.12	217.05	179.02
66982	Cataract surgery, complex		T	0246	23.5664	1,450.54	495.96	290.11
66983	Cataract surg w/iol, 1 stage		T	0246	23.5664	1,450.54	495.96	290.11
66984	Cataract surg w/iol, 1 stage		T	0246	23.5664	1,450.54	495.96	290.11
66985	Insert lens prosthesis		T	0246	23.5664	1,450.54	495.96	290.11
66986	Exchange lens prosthesis		T	0246	23.5664	1,450.54	495.96	290.11
66990	Ophthalmic endoscope add-on		N					
66999	Eye surgery procedure		T	0232	5.9800	368.07	92.21	73.61
67005	Partial removal of eye fluid		T	0237	26.9305	1,657.60		331.52
67010	Partial removal of eye fluid		T	0237	26.9305	1,657.60		331.52
67015	Release of eye fluid		T	0237	26.9305	1,657.60		331.52
67025	Replace eye fluid		T	0237	26.9305	1,657.60		331.52
67027	Implant eye drug system		T	0672	36.8820	2,270.12		454.02
67028	Injection eye drug		T	0235	4.0750	250.82	61.14	50.16
67030	Incise inner eye strands		T	0236	16.3433	1,005.95		201.19
67031	Laser surgery, eye strands		T	0247	5.1266	315.55	104.31	63.11
67036	Removal of inner eye fluid		T	0672	36.8820	2,270.12		454.02
67038	Strip retinal membrane		T	0672	36.8820	2,270.12		454.02
67039	Laser treatment of retina		T	0672	36.8820	2,270.12		454.02
67040	Laser treatment of retina		T	0672	36.8820	2,270.12		454.02
67101	Repair detached retina		T	0236	16.3433	1,005.95		201.19
67105	Repair detached retina		T	0248	5.0285	309.51	95.08	61.90
67107	Repair detached retina		T	0672	36.8820	2,270.12		454.02
67108	Repair detached retina		T	0672	36.8820	2,270.12		454.02
67110	Repair detached retina		T	0236	16.3433	1,005.95		201.19
67112	Rerepair detached retina		T	0672	36.8820	2,270.12		454.02
67115	Release encircling material		T	0236	16.3433	1,005.95		201.19
67120	Remove eye implant material		T	0236	16.3433	1,005.95		201.19
67121	Remove eye implant material		T	0237	26.9305	1,657.60		331.52
67141	Treatment of retina		T	0235	4.0750	250.82	61.14	50.16
67145	Treatment of retina		T	0248	5.0285	309.51	95.08	61.90
67208	Treatment of retinal lesion		T	0236	16.3433	1,005.95		201.19
67210	Treatment of retinal lesion		T	0248	5.0285	309.51	95.08	61.90
67218	Treatment of retinal lesion		T	0236	16.3433	1,005.95		201.19
67220	Treatment of choroid lesion		T	0235	4.0750	250.82	61.14	50.16
67221	Ocular photodynamic ther		T	0235	4.0750	250.82	61.14	50.16
67225	Eye photodynamic ther add-on		T	0235	4.0750	250.82	61.14	50.16
67227	Treatment of retinal lesion	CH	T	0237	26.9305	1,657.60		331.52
67228	Treatment of retinal lesion		T	0248	5.0285	309.51	95.08	61.90
67250	Reinforce eye wall		T	0240	17.0126	1,047.14	307.90	209.43
67255	Reinforce/graft eye wall		T	0237	26.9305	1,657.60		331.52
67299	Eye surgery procedure		T	0235	4.0750	250.82	61.14	50.16
67311	Revise eye muscle		T	0243	21.2885	1,310.33	431.09	262.07
67312	Revise two eye muscles		T	0243	21.2885	1,310.33	431.09	262.07
67314	Revise eye muscle		T	0243	21.2885	1,310.33	431.09	262.07
67316	Revise two eye muscles		T	0243	21.2885	1,310.33	431.09	262.07
67318	Revise eye muscle(s)		T	0243	21.2885	1,310.33	431.09	262.07
67320	Revise eye muscle(s) add-on		T	0243	21.2885	1,310.33	431.09	262.07
67331	Eye surgery follow-up add-on		T	0243	21.2885	1,310.33	431.09	262.07
67332	Rerevise eye muscles add-on		T	0243	21.2885	1,310.33	431.09	262.07
67334	Revise eye muscle w/suture		T	0243	21.2885	1,310.33	431.09	262.07
67335	Eye suture during surgery		T	0243	21.2885	1,310.33	431.09	262.07
67340	Revise eye muscle add-on		T	0243	21.2885	1,310.33	431.09	262.07
67343	Release eye tissue		T	0243	21.2885	1,310.33	431.09	262.07
67345	Destroy nerve of eye muscle		T	0238	2.8099	172.95		34.59
67350	Biopsy eye muscle		T	0699	13.9509	858.69		171.74
67399	Eye muscle surgery procedure		T	0243	21.2885	1,310.33	431.09	262.07
67400	Explore/biopsy eye socket		T	0241	24.8502	1,529.55	384.47	305.91
67405	Explore/drain eye socket		T	0241	24.8502	1,529.55	384.47	305.91
67412	Explore/treat eye socket		T	0241	24.8502	1,529.55	384.47	305.91
67413	Explore/treat eye socket		T	0241	24.8502	1,529.55	384.47	305.91
67414	Explr/decompress eye socket		T	0242	35.5217	2,186.40	597.36	437.28
67415	Aspiration, orbital contents		T	0240	17.0126	1,047.14	307.90	209.43

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67420	Explore/treat eye socket		T	0242	35.5217	2,186.40	597.36	437.28
67430	Explore/treat eye socket		T	0242	35.5217	2,186.40	597.36	437.28
67440	Explore/drain eye socket		T	0242	35.5217	2,186.40	597.36	437.28
67445	Explr/decompress eye socket		T	0242	35.5217	2,186.40	597.36	437.28
67450	Explore/biopsy eye socket		T	0242	35.5217	2,186.40	597.36	437.28
67500	Inject/treat eye socket		S	0231	2.1934	135.01		27.00
67505	Inject/treat eye socket		T	0238	2.8099	172.95		34.59
67515	Inject/treat eye socket		T	0238	2.8099	172.95		34.59
67550	Insert eye socket implant		T	0242	35.5217	2,186.40	597.36	437.28
67560	Revise eye socket implant		T	0241	24.8502	1,529.55	384.47	305.91
67570	Decompress optic nerve		T	0242	35.5217	2,186.40	597.36	437.28
67599	Orbit surgery procedure		T	0238	2.8099	172.95		34.59
67700	Drainage of eyelid abscess		T	0238	2.8099	172.95		34.59
67710	Incision of eyelid		T	0239	6.9354	426.88		85.38
67715	Incision of eyelid fold		T	0240	17.0126	1,047.14	307.90	209.43
67800	Remove eyelid lesion		T	0238	2.8099	172.95		34.59
67801	Remove eyelid lesions		T	0239	6.9354	426.88		85.38
67805	Remove eyelid lesions		T	0238	2.8099	172.95		34.59
67808	Remove eyelid lesion(s)		T	0240	17.0126	1,047.14	307.90	209.43
67810	Biopsy of eyelid		T	0238	2.8099	172.95		34.59
67820	Revise eyelashes		S	0698	1.2244	75.36	16.52	15.07
67825	Revise eyelashes		T	0238	2.8099	172.95		34.59
67830	Revise eyelashes		T	0239	6.9354	426.88		85.38
67835	Revise eyelashes		T	0240	17.0126	1,047.14	307.90	209.43
67840	Remove eyelid lesion		T	0239	6.9354	426.88		85.38
67850	Treat eyelid lesion		T	0239	6.9354	426.88		85.38
67875	Closure of eyelid by suture		T	0239	6.9354	426.88		85.38
67880	Revision of eyelid		T	0233	14.9969	923.07	266.33	184.61
67882	Revision of eyelid		T	0240	17.0126	1,047.14	307.90	209.43
67900	Repair brow defect		T	0240	17.0126	1,047.14	307.90	209.43
67901	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67902	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67903	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67904	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67906	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67908	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67909	Revise eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67911	Revise eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67912	Correction eyelid w/implant		T	0240	17.0126	1,047.14	307.90	209.43
67914	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67915	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67916	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67917	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67921	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67922	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67923	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67924	Repair eyelid defect		T	0240	17.0126	1,047.14	307.90	209.43
67930	Repair eyelid wound		T	0240	17.0126	1,047.14	307.90	209.43
67935	Repair eyelid wound		T	0240	17.0126	1,047.14	307.90	209.43
67938	Remove eyelid foreign body		S	0698	1.2244	75.36	16.52	15.07
67950	Revision of eyelid		T	0240	17.0126	1,047.14	307.90	209.43
67961	Revision of eyelid		T	0240	17.0126	1,047.14	307.90	209.43
67966	Revision of eyelid		T	0240	17.0126	1,047.14	307.90	209.43
67971	Reconstruction of eyelid		T	0241	24.8502	1,529.55	384.47	305.91
67973	Reconstruction of eyelid		T	0241	24.8502	1,529.55	384.47	305.91
67974	Reconstruction of eyelid		T	0241	24.8502	1,529.55	384.47	305.91
67975	Reconstruction of eyelid		T	0240	17.0126	1,047.14	307.90	209.43
67999	Revision of eyelid		T	0238	2.8099	172.95		34.59
68020	Incise/drain eyelid lining		T	0240	17.0126	1,047.14	307.90	209.43
68040	Treatment of eyelid lesions		S	0698	1.2244	75.36	16.52	15.07
68100	Biopsy of eyelid lining		T	0232	5.9800	368.07	92.21	73.61
68110	Remove eyelid lining lesion		T	0699	13.9509	858.69		171.74
68115	Remove eyelid lining lesion		T	0240	17.0126	1,047.14	307.90	209.43
68130	Remove eyelid lining lesion		T	0233	14.9969	923.07	266.33	184.61
68135	Remove eyelid lining lesion		T	0239	6.9354	426.88		85.38
68200	Treat eyelid by injection		S	0230	0.8126	50.02	14.97	10.00
68320	Revise/graft eyelid lining		T	0240	17.0126	1,047.14	307.90	209.43
68325	Revise/graft eyelid lining	CH	T	0241	24.8502	1,529.55	384.47	305.91
68326	Revise/graft eyelid lining		T	0241	24.8502	1,529.55	384.47	305.91
68328	Revise/graft eyelid lining		T	0241	24.8502	1,529.55	384.47	305.91

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
68330	Revise eyelid lining		T	0234	22.9479	1,412.47	511.31	282.49
68335	Revise/graft eyelid lining		T	0241	24.8502	1,529.55	384.47	305.91
68340	Separate eyelid adhesions		T	0240	17.0126	1,047.14	307.90	209.43
68360	Revise eyelid lining		T	0234	22.9479	1,412.47	511.31	282.49
68362	Revise eyelid lining		T	0234	22.9479	1,412.47	511.31	282.49
68371	Harvest eye tissue, alograft		T	0233	14.9969	923.07	266.33	184.61
68399	Eyelid lining surgery		T	0238	2.8099	172.95		34.59
68400	Incise/drain tear gland		T	0238	2.8099	172.95		34.59
68420	Incise/drain tear sac		T	0240	17.0126	1,047.14	307.90	209.43
68440	Incise tear duct opening		T	0238	2.8099	172.95		34.59
68500	Removal of tear gland		T	0241	24.8502	1,529.55	384.47	305.91
68505	Partial removal, tear gland		T	0241	24.8502	1,529.55	384.47	305.91
68510	Biopsy of tear gland		T	0240	17.0126	1,047.14	307.90	209.43
68520	Removal of tear sac		T	0241	24.8502	1,529.55	384.47	305.91
68525	Biopsy of tear sac		T	0240	17.0126	1,047.14	307.90	209.43
68530	Clearance of tear duct		T	0240	17.0126	1,047.14	307.90	209.43
68540	Remove tear gland lesion		T	0241	24.8502	1,529.55	384.47	305.91
68550	Remove tear gland lesion	CH	T	0241	24.8502	1,529.55	384.47	305.91
68700	Repair tear ducts		T	0241	24.8502	1,529.55	384.47	305.91
68705	Revise tear duct opening		T	0238	2.8099	172.95		34.59
68720	Create tear sac drain	CH	T	0241	24.8502	1,529.55	384.47	305.91
68745	Create tear duct drain		T	0241	24.8502	1,529.55	384.47	305.91
68750	Create tear duct drain	CH	T	0241	24.8502	1,529.55	384.47	305.91
68760	Close tear duct opening	CH	S	0231	2.1934	135.01		27.00
68761	Close tear duct opening		S	0231	2.1934	135.01		27.00
68770	Close tear system fistula		T	0240	17.0126	1,047.14	307.90	209.43
68801	Dilate tear duct opening		S	0698	1.2244	75.36	16.52	15.07
68810	Probe nasolacrimal duct		S	0231	2.1934	135.01		27.00
68811	Probe nasolacrimal duct		T	0240	17.0126	1,047.14	307.90	209.43
68815	Probe nasolacrimal duct		T	0240	17.0126	1,047.14	307.90	209.43
68840	Explore/irrigate tear ducts	CH	S	0698	1.2244	75.36	16.52	15.07
68850	Injection for tear sac x-ray		N					
68899	Tear duct system surgery	CH	T	0238	2.8099	172.95		34.59
69000	Drain external ear lesion		T	0006	1.4821	91.22	21.76	18.24
69005	Drain external ear lesion		T	0008	17.4686	1,075.21		215.04
69020	Drain outer ear canal lesion		T	0006	1.4821	91.22	21.76	18.24
69100	Biopsy of external ear		T	0019	4.0123	246.96	71.87	49.39
69105	Biopsy of external ear canal		T	0253	16.4494	1,012.48	282.29	202.50
69110	Remove external ear, partial		T	0021	14.9563	920.58	219.48	184.12
69120	Removal of external ear		T	0254	23.1564	1,425.30	321.35	285.06
69140	Remove ear canal lesion(s)		T	0254	23.1564	1,425.30	321.35	285.06
69145	Remove ear canal lesion(s)		T	0021	14.9563	920.58	219.48	184.12
69150	Extensive ear canal surgery		T	0252	7.7261	475.55	111.84	95.11
69200	Clear outer ear canal		X	0340	0.6211	38.23		7.65
69205	Clear outer ear canal		T	0022	19.9760	1,229.54	354.45	245.91
69210	Remove impacted ear wax		X	0340	0.6211	38.23		7.65
69220	Clean out mastoid cavity		T	0012	0.8076	49.71	10.30	9.94
69222	Clean out mastoid cavity	CH	T	0252	7.7261	475.55	111.84	95.11
69300	Revise external ear		T	0254	23.1564	1,425.30	321.35	285.06
69310	Rebuild outer ear canal		T	0256	37.7719	2,324.90		464.98
69320	Rebuild outer ear canal		T	0256	37.7719	2,324.90		464.98
69399	Outer ear surgery procedure		T	0251	2.3768	146.29		29.26
69400	Inflate middle ear canal		T	0251	2.3768	146.29		29.26
69401	Inflate middle ear canal		T	0251	2.3768	146.29		29.26
69405	Catheterize middle ear canal		T	0252	7.7261	475.55	111.84	95.11
69420	Incision of eardrum		T	0251	2.3768	146.29		29.26
69421	Incision of eardrum		T	0253	16.4494	1,012.48	282.29	202.50
69424	Remove ventilating tube		T	0252	7.7261	475.55	111.84	95.11
69433	Create eardrum opening		T	0252	7.7261	475.55	111.84	95.11
69436	Create eardrum opening		T	0253	16.4494	1,012.48	282.29	202.50
69440	Exploration of middle ear		T	0254	23.1564	1,425.30	321.35	285.06
69450	Eardrum revision		T	0256	37.7719	2,324.90		464.98
69501	Mastoidectomy		T	0256	37.7719	2,324.90		464.98
69502	Mastoidectomy		T	0254	23.1564	1,425.30	321.35	285.06
69505	Remove mastoid structures		T	0256	37.7719	2,324.90		464.98
69511	Extensive mastoid surgery		T	0256	37.7719	2,324.90		464.98
69530	Extensive mastoid surgery		T	0256	37.7719	2,324.90		464.98
69540	Remove ear lesion		T	0253	16.4494	1,012.48	282.29	202.50
69550	Remove ear lesion		T	0256	37.7719	2,324.90		464.98
69552	Remove ear lesion		T	0256	37.7719	2,324.90		464.98

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69601	Mastoid surgery revision		T	0256	37.7719	2,324.90		464.98
69602	Mastoid surgery revision		T	0256	37.7719	2,324.90		464.98
69603	Mastoid surgery revision		T	0256	37.7719	2,324.90		464.98
69604	Mastoid surgery revision		T	0256	37.7719	2,324.90		464.98
69605	Mastoid surgery revision		T	0256	37.7719	2,324.90		464.98
69610	Repair of eardrum		T	0254	23.1564	1,425.30	321.35	285.06
69620	Repair of eardrum		T	0254	23.1564	1,425.30	321.35	285.06
69631	Repair eardrum structures		T	0256	37.7719	2,324.90		464.98
69632	Rebuild eardrum structures		T	0256	37.7719	2,324.90		464.98
69633	Rebuild eardrum structures		T	0256	37.7719	2,324.90		464.98
69635	Repair eardrum structures		T	0256	37.7719	2,324.90		464.98
69636	Rebuild eardrum structures		T	0256	37.7719	2,324.90		464.98
69637	Rebuild eardrum structures		T	0256	37.7719	2,324.90		464.98
69641	Revise middle ear&mastoid		T	0256	37.7719	2,324.90		464.98
69642	Revise middle ear&mastoid		T	0256	37.7719	2,324.90		464.98
69643	Revise middle ear&mastoid		T	0256	37.7719	2,324.90		464.98
69644	Revise middle ear&mastoid		T	0256	37.7719	2,324.90		464.98
69645	Revise middle ear&mastoid		T	0256	37.7719	2,324.90		464.98
69646	Revise middle ear&mastoid		T	0256	37.7719	2,324.90		464.98
69650	Release middle ear bone		T	0254	23.1564	1,425.30	321.35	285.06
69660	Revise middle ear bone		T	0256	37.7719	2,324.90		464.98
69661	Revise middle ear bone		T	0256	37.7719	2,324.90		464.98
69662	Revise middle ear bone		T	0256	37.7719	2,324.90		464.98
69666	Repair middle ear structures		T	0256	37.7719	2,324.90		464.98
69667	Repair middle ear structures		T	0256	37.7719	2,324.90		464.98
69670	Remove mastoid air cells		T	0256	37.7719	2,324.90		464.98
69676	Remove middle ear nerve		T	0256	37.7719	2,324.90		464.98
69700	Close mastoid fistula		T	0256	37.7719	2,324.90		464.98
69711	Remove/repair hearing aid		T	0256	37.7719	2,324.90		464.98
69714	Implant temple bone w/stimul		T	0256	37.7719	2,324.90		464.98
69715	Temple bne implnt w/stimulat		T	0256	37.7719	2,324.90		464.98
69717	Temple bone implant revision		T	0256	37.7719	2,324.90		464.98
69718	Revise temple bone implant		T	0256	37.7719	2,324.90		464.98
69720	Release facial nerve		T	0256	37.7719	2,324.90		464.98
69725	Release facial nerve		T	0256	37.7719	2,324.90		464.98
69740	Repair facial nerve		T	0256	37.7719	2,324.90		464.98
69745	Repair facial nerve		T	0256	37.7719	2,324.90		464.98
69799	Middle ear surgery procedure		T	0251	2.3768	146.29		29.26
69801	Incise inner ear		T	0256	37.7719	2,324.90		464.98
69802	Incise inner ear		T	0256	37.7719	2,324.90		464.98
69805	Explore inner ear		T	0256	37.7719	2,324.90		464.98
69806	Explore inner ear		T	0256	37.7719	2,324.90		464.98
69820	Establish inner ear window		T	0256	37.7719	2,324.90		464.98
69840	Revise inner ear window		T	0256	37.7719	2,324.90		464.98
69905	Remove inner ear		T	0256	37.7719	2,324.90		464.98
69910	Remove inner ear&mastoid		T	0256	37.7719	2,324.90		464.98
69915	Incise inner ear nerve		T	0256	37.7719	2,324.90		464.98
69930	Implant cochlear device		T	0259	406.8232	25,040.37	8,698.43	5,008.07
69949	Inner ear surgery procedure		T	0251	2.3768	146.29		29.26
69955	Release facial nerve		T	0256	37.7719	2,324.90		464.98
69960	Release inner ear canal		T	0256	37.7719	2,324.90		464.98
69979	Temporal bone surgery		T	0251	2.3768	146.29		29.26
69990	Microsurgery add-on		N					
70010	Contrast x-ray of brain		S	0274	2.6182	161.15	64.46	32.23
70015	Contrast x-ray of brain		S	0274	2.6182	161.15	64.46	32.23
70030	X-ray eye for foreign body		X	0260	0.7276	44.78		8.96
70100	X-ray exam of jaw		X	0260	0.7276	44.78		8.96
70110	X-ray exam of jaw		X	0260	0.7276	44.78		8.96
70120	X-ray exam of mastoids		X	0260	0.7276	44.78		8.96
70130	X-ray exam of mastoids		X	0260	0.7276	44.78		8.96
70134	X-ray exam of middle ear		X	0261	1.2515	77.03		15.41
70140	X-ray exam of facial bones		X	0260	0.7276	44.78		8.96
70150	X-ray exam of facial bones		X	0260	0.7276	44.78		8.96
70160	X-ray exam of nasal bones		X	0260	0.7276	44.78		8.96
70170	X-ray exam of tear duct		X	0264	2.9791	183.37	70.84	36.67
70190	X-ray exam of eye sockets		X	0260	0.7276	44.78		8.96
70200	X-ray exam of eye sockets		X	0260	0.7276	44.78		8.96
70210	X-ray exam of sinuses		X	0260	0.7276	44.78		8.96
70220	X-ray exam of sinuses		X	0260	0.7276	44.78		8.96
70240	X-ray exam, pituitary saddle		X	0260	0.7276	44.78		8.96

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
70250	X-ray exam of skull		X	0260	0.7276	44.78		8.96
70260	X-ray exam of skull		X	0261	1.2515	77.03		15.41
70300	X-ray exam of teeth		X	0262	0.5818	35.81		7.16
70310	X-ray exam of teeth		X	0262	0.5818	35.81		7.16
70320	Full mouth x-ray of teeth		X	0262	0.5818	35.81		7.16
70328	X-ray exam of jaw joint		X	0260	0.7276	44.78		8.96
70330	X-ray exam of jaw joints		X	0260	0.7276	44.78		8.96
70332	X-ray exam of jaw joint		S	0275	3.7021	227.87	69.09	45.57
70336	Magnetic image, jaw joint		S	0335	4.6629	287.01	114.80	57.40
70350	X-ray head for orthodontia		X	0260	0.7276	44.78		8.96
70355	Panoramic x-ray of jaws		X	0260	0.7276	44.78		8.96
70360	X-ray exam of neck		X	0260	0.7276	44.78		8.96
70370	Throat x-ray&fluoroscopy		X	0272	1.2985	79.92	31.64	15.98
70371	Speech evaluation, complex		X	0272	1.2985	79.92	31.64	15.98
70373	Contrast x-ray of larynx		X	0263	1.7120	105.38	23.77	21.08
70380	X-ray exam of salivary gland		X	0260	0.7276	44.78		8.96
70390	X-ray exam of salivary duct		X	0263	1.7120	105.38	23.77	21.08
70450	Ct head/brain w/o dye		S	0332	3.1631	194.69	75.24	38.94
70460	Ct head/brain w/dye		S	0283	4.1858	257.64	102.17	51.53
70470	Ct head/brain w/o&w/dye		S	0333	5.0020	307.88	121.52	61.58
70480	Ct orbit/ear/fossa w/o dye		S	0332	3.1631	194.69	75.24	38.94
70481	Ct orbit/ear/fossa w/dye		S	0283	4.1858	257.64	102.17	51.53
70482	Ct orbit/ear/fossa w/o&w/dye		S	0333	5.0020	307.88	121.52	61.58
70486	Ct maxillofacial w/o dye		S	0332	3.1631	194.69	75.24	38.94
70487	Ct maxillofacial w/dye		S	0283	4.1858	257.64	102.17	51.53
70488	Ct maxillofacial w/o&w/dye		S	0333	5.0020	307.88	121.52	61.58
70490	Ct soft tissue neck w/o dye		S	0332	3.1631	194.69	75.24	38.94
70491	Ct soft tissue neck w/dye		S	0283	4.1858	257.64	102.17	51.53
70492	Ct sft tsue nck w/o&w/dye		S	0333	5.0020	307.88	121.52	61.58
70496	Ct angiography, head		S	0662	4.9203	302.85	118.88	60.57
70498	Ct angiography, neck		S	0662	4.9203	302.85	118.88	60.57
70540	Mri orbit/face/neck w/o dye		S	0336	5.8500	360.07	139.68	72.01
70542	Mri orbit/face/neck w/dye		S	0284	6.2589	385.24	148.40	77.05
70543	Mri orbt/fac/nck w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
70544	Mr angiography head w/o dye		S	0336	5.8500	360.07	139.68	72.01
70545	Mr angiography head w/dye		S	0284	6.2589	385.24	148.40	77.05
70546	Mr angiograph head w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
70547	Mr angiography neck w/o dye		S	0336	5.8500	360.07	139.68	72.01
70548	Mr angiography neck w/dye		S	0284	6.2589	385.24	148.40	77.05
70549	Mr angiograph neck w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
70551	Mri brain w/o dye		S	0336	5.8500	360.07	139.68	72.01
70552	Mri brain w/dye		S	0284	6.2589	385.24	148.40	77.05
70553	Mri brain w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
70557	Mri brain w/o dye		S	0336	5.8500	360.07	139.68	72.01
70558	Mri brain w/dye		S	0284	6.2589	385.24	148.40	77.05
70559	Mri brain w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
71010	Chest x-ray		X	0260	0.7276	44.78		8.96
71015	Chest x-ray		X	0260	0.7276	44.78		8.96
71020	Chest x-ray		X	0260	0.7276	44.78		8.96
71021	Chest x-ray		X	0260	0.7276	44.78		8.96
71022	Chest x-ray		X	0260	0.7276	44.78		8.96
71023	Chest x-ray and fluoroscopy		X	0272	1.2985	79.92	31.64	15.98
71030	Chest x-ray		X	0260	0.7276	44.78		8.96
71034	Chest x-ray and fluoroscopy		X	0272	1.2985	79.92	31.64	15.98
71035	Chest x-ray		X	0260	0.7276	44.78		8.96
71040	Contrast x-ray of bronchi		X	0263	1.7120	105.38	23.77	21.08
71060	Contrast x-ray of bronchi		X	0263	1.7120	105.38	23.77	21.08
71090	X-ray&pacemaker insertion		X	0272	1.2985	79.92	31.64	15.98
71100	X-ray exam of ribs		X	0260	0.7276	44.78		8.96
71101	X-ray exam of ribs/chest		X	0260	0.7276	44.78		8.96
71110	X-ray exam of ribs		X	0260	0.7276	44.78		8.96
71111	X-ray exam of ribs/chest		X	0261	1.2515	77.03		15.41
71120	X-ray exam of breastbone		X	0260	0.7276	44.78		8.96
71130	X-ray exam of breastbone		X	0260	0.7276	44.78		8.96
71250	Ct thorax w/o dye		S	0332	3.1631	194.69	75.24	38.94
71260	Ct thorax w/dye		S	0283	4.1858	257.64	102.17	51.53
71270	Ct thorax w/o&w/dye		S	0333	5.0020	307.88	121.52	61.58
71275	Ct angiography, chest		S	0662	4.9203	302.85	118.88	60.57
71550	Mri chest w/o dye		S	0336	5.8500	360.07	139.68	72.01
71551	Mri chest w/dye		S	0284	6.2589	385.24	148.40	77.05

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
71552	Mri chest w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
72010	X-ray exam of spine		X	0260	0.7276	44.78		8.96
72020	X-ray exam of spine		X	0260	0.7276	44.78		8.96
72040	X-ray exam of neck spine		X	0260	0.7276	44.78		8.96
72050	X-ray exam of neck spine		X	0261	1.2515	77.03		15.41
72052	X-ray exam of neck spine		X	0261	1.2515	77.03		15.41
72069	X-ray exam of trunk spine		X	0260	0.7276	44.78		8.96
72070	X-ray exam of thoracic spine		X	0260	0.7276	44.78		8.96
72072	X-ray exam of thoracic spine		X	0260	0.7276	44.78		8.96
72074	X-ray exam of thoracic spine		X	0260	0.7276	44.78		8.96
72080	X-ray exam of trunk spine		X	0260	0.7276	44.78		8.96
72090	X-ray exam of trunk spine		X	0261	1.2515	77.03		15.41
72100	X-ray exam of lower spine		X	0260	0.7276	44.78		8.96
72110	X-ray exam of lower spine		X	0261	1.2515	77.03		15.41
72114	X-ray exam of lower spine		X	0261	1.2515	77.03		15.41
72120	X-ray exam of lower spine		X	0261	1.2515	77.03		15.41
72125	Ct neck spine w/o dye		S	0332	3.1631	194.69	75.24	38.94
72126	Ct neck spine w/dye		S	0283	4.1858	257.64	102.17	51.53
72127	Ct neck spine w/o&w/dye		S	0333	5.0020	307.88	121.52	61.58
72128	Ct chest spine w/o dye		S	0332	3.1631	194.69	75.24	38.94
72129	Ct chest spine w/dye		S	0283	4.1858	257.64	102.17	51.53
72130	Ct chest spine w/o&w/dye		S	0333	5.0020	307.88	121.52	61.58
72131	Ct lumbar spine w/o dye		S	0332	3.1631	194.69	75.24	38.94
72132	Ct lumbar spine w/dye		S	0283	4.1858	257.64	102.17	51.53
72133	Ct lumbar spine w/o&w/dye		S	0333	5.0020	307.88	121.52	61.58
72141	Mri neck spine w/o dye		S	0336	5.8500	360.07	139.68	72.01
72142	Mri neck spine w/dye		S	0284	6.2589	385.24	148.40	77.05
72146	Mri chest spine w/o dye		S	0336	5.8500	360.07	139.68	72.01
72147	Mri chest spine w/dye		S	0284	6.2589	385.24	148.40	77.05
72148	Mri lumbar spine w/o dye		S	0336	5.8500	360.07	139.68	72.01
72149	Mri lumbar spine w/dye		S	0284	6.2589	385.24	148.40	77.05
72156	Mri neck spine w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
72157	Mri chest spine w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
72158	Mri lumbar spine w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
72170	X-ray exam of pelvis		X	0260	0.7276	44.78		8.96
72190	X-ray exam of pelvis		X	0260	0.7276	44.78		8.96
72191	Ct angiograph pelv w/o&w/dye		S	0662	4.9203	302.85	118.88	60.57
72192	Ct pelvis w/o dye		S	0332	3.1631	194.69	75.24	38.94
72193	Ct pelvis w/dye		S	0283	4.1858	257.64	102.17	51.53
72194	Ct pelvis w/o&w/dye		S	0333	5.0020	307.88	121.52	61.58
72195	Mri pelvis w/o dye		S	0336	5.8500	360.07	139.68	72.01
72196	Mri pelvis w/dye		S	0284	6.2589	385.24	148.40	77.05
72197	Mri pelvis w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
72200	X-ray exam sacroiliac joints		X	0260	0.7276	44.78		8.96
72202	X-ray exam sacroiliac joints		X	0260	0.7276	44.78		8.96
72220	X-ray exam of tailbone		X	0260	0.7276	44.78		8.96
72240	Contrast x-ray of neck spine		S	0274	2.6182	161.15	64.46	32.23
72255	Contrast x-ray, thorax spine		S	0274	2.6182	161.15	64.46	32.23
72265	Contrast x-ray, lower spine		S	0274	2.6182	161.15	64.46	32.23
72270	Contrast x-ray, spine		S	0274	2.6182	161.15	64.46	32.23
72275	Epidurography		S	0274	2.6182	161.15	64.46	32.23
72285	X-ray c/t spine disk		S	0388	14.2706	878.37	289.72	175.67
72295	X-ray of lower spine disk		S	0388	14.2706	878.37	289.72	175.67
73000	X-ray exam of collar bone		X	0260	0.7276	44.78		8.96
73010	X-ray exam of shoulder blade		X	0260	0.7276	44.78		8.96
73020	X-ray exam of shoulder		X	0260	0.7276	44.78		8.96
73030	X-ray exam of shoulder		X	0260	0.7276	44.78		8.96
73040	Contrast x-ray of shoulder		S	0275	3.7021	227.87	69.09	45.57
73050	X-ray exam of shoulders		X	0260	0.7276	44.78		8.96
73060	X-ray exam of humerus		X	0260	0.7276	44.78		8.96
73070	X-ray exam of elbow		X	0260	0.7276	44.78		8.96
73080	X-ray exam of elbow		X	0260	0.7276	44.78		8.96
73085	Contrast x-ray of elbow		S	0275	3.7021	227.87	69.09	45.57
73090	X-ray exam of forearm		X	0260	0.7276	44.78		8.96
73092	X-ray exam of arm, infant		X	0260	0.7276	44.78		8.96
73100	X-ray exam of wrist		X	0260	0.7276	44.78		8.96
73110	X-ray exam of wrist		X	0260	0.7276	44.78		8.96
73115	Contrast x-ray of wrist		S	0275	3.7021	227.87	69.09	45.57
73120	X-ray exam of hand		X	0260	0.7276	44.78		8.96
73130	X-ray exam of hand		X	0260	0.7276	44.78		8.96

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73140	X-ray exam of finger(s)		X	0260	0.7276	44.78		8.96
73200	Ct upper extremity w/o dye		S	0332	3.1631	194.69	75.24	38.94
73201	Ct upper extremity w/dye		S	0283	4.1858	257.64	102.17	51.53
73202	Ct uppr extremity w/o&w/dye		S	0333	5.0020	307.88	121.52	61.58
73206	Ct angio upr extrm w/o&w/dye		S	0662	4.9203	302.85	118.88	60.57
73218	Mri upper extremity w/o dye		S	0336	5.8500	360.07	139.68	72.01
73219	Mri upper extremity w/dye		S	0284	6.2589	385.24	148.40	77.05
73220	Mri uppr extremity w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
73221	Mri joint upr extrem w/o dye		S	0336	5.8500	360.07	139.68	72.01
73222	Mri joint upr extrem w/dye		S	0284	6.2589	385.24	148.40	77.05
73223	Mri joint upr extr w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
73500	X-ray exam of hip		X	0260	0.7276	44.78		8.96
73510	X-ray exam of hip		X	0260	0.7276	44.78		8.96
73520	X-ray exam of hips		X	0261	1.2515	77.03		15.41
73525	Contrast x-ray of hip		S	0275	3.7021	227.87	69.09	45.57
73530	X-ray exam of hip		X	0261	1.2515	77.03		15.41
73540	X-ray exam of pelvis&hips		X	0260	0.7276	44.78		8.96
73542	X-ray exam, sacroiliac joint		S	0275	3.7021	227.87	69.09	45.57
73550	X-ray exam of thigh		X	0260	0.7276	44.78		8.96
73560	X-ray exam of knee, 1 or 2		X	0260	0.7276	44.78		8.96
73562	X-ray exam of knee, 3		X	0260	0.7276	44.78		8.96
73564	X-ray exam, knee, 4 or more		X	0260	0.7276	44.78		8.96
73565	X-ray exam of knees		X	0260	0.7276	44.78		8.96
73580	Contrast x-ray of knee joint		S	0275	3.7021	227.87	69.09	45.57
73590	X-ray exam of lower leg		X	0260	0.7276	44.78		8.96
73592	X-ray exam of leg, infant		X	0260	0.7276	44.78		8.96
73600	X-ray exam of ankle		X	0260	0.7276	44.78		8.96
73610	X-ray exam of ankle		X	0260	0.7276	44.78		8.96
73615	Contrast x-ray of ankle		S	0275	3.7021	227.87	69.09	45.57
73620	X-ray exam of foot		X	0260	0.7276	44.78		8.96
73630	X-ray exam of foot		X	0260	0.7276	44.78		8.96
73650	X-ray exam of heel		X	0260	0.7276	44.78		8.96
73660	X-ray exam of toe(s)		X	0260	0.7276	44.78		8.96
73700	Ct lower extremity w/o dye		S	0332	3.1631	194.69	75.24	38.94
73701	Ct lower extremity w/dye		S	0283	4.1858	257.64	102.17	51.53
73702	Ct lwr extremity w/o&w/dye		S	0333	5.0020	307.88	121.52	61.58
73706	Ct angio lwr extr w/o&w/dye		S	0662	4.9203	302.85	118.88	60.57
73718	Mri lower extremity w/o dye		S	0336	5.8500	360.07	139.68	72.01
73719	Mri lower extremity w/dye		S	0284	6.2589	385.24	148.40	77.05
73720	Mri lwr extremity w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
73721	Mri jnt of lwr extre w/o dye		S	0336	5.8500	360.07	139.68	72.01
73722	Mri joint of lwr extr w/dye		S	0284	6.2589	385.24	148.40	77.05
73723	Mri joint lwr extr w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
74000	X-ray exam of abdomen		X	0260	0.7276	44.78		8.96
74010	X-ray exam of abdomen		X	0260	0.7276	44.78		8.96
74020	X-ray exam of abdomen		X	0260	0.7276	44.78		8.96
74022	X-ray exam series, abdomen		X	0261	1.2515	77.03		15.41
74150	Ct abdomen w/o dye		S	0332	3.1631	194.69	75.24	38.94
74160	Ct abdomen w/dye		S	0283	4.1858	257.64	102.17	51.53
74170	Ct abdomen w/o&w/dye		S	0333	5.0020	307.88	121.52	61.58
74175	Ct angio abdom w/o&w/dye		S	0662	4.9203	302.85	118.88	60.57
74181	Mri abdomen w/o dye		S	0336	5.8500	360.07	139.68	72.01
74182	Mri abdomen w/dye		S	0284	6.2589	385.24	148.40	77.05
74183	Mri abdomen w/o&w/dye		S	0337	8.3423	513.48	202.50	102.70
74190	X-ray exam of peritoneum		X	0264	2.9791	183.37	70.84	36.67
74210	Contrst x-ray exam of throat		S	0276	1.4519	89.37	34.97	17.87
74220	Contrast x-ray, esophagus		S	0276	1.4519	89.37	34.97	17.87
74230	Cine/vid x-ray, throat/esoph		S	0276	1.4519	89.37	34.97	17.87
74235	Remove esophagus obstruction	CH	S	0257	0.9770	60.14		12.03
74240	X-ray exam, upper gi tract		S	0276	1.4519	89.37	34.97	17.87
74241	X-ray exam, upper gi tract		S	0276	1.4519	89.37	34.97	17.87
74245	X-ray exam, upper gi tract		S	0277	2.2764	140.11	54.63	28.02
74246	Contrst x-ray uppr gi tract		S	0276	1.4519	89.37	34.97	17.87
74247	Contrst x-ray uppr gi tract		S	0276	1.4519	89.37	34.97	17.87
74249	Contrst x-ray uppr gi tract		S	0277	2.2764	140.11	54.63	28.02
74250	X-ray exam of small bowel		S	0276	1.4519	89.37	34.97	17.87
74251	X-ray exam of small bowel		S	0277	2.2764	140.11	54.63	28.02
74260	X-ray exam of small bowel	CH	S	0276	1.4519	89.37	34.97	17.87
74270	Contrast x-ray exam of colon		S	0276	1.4519	89.37	34.97	17.87
74280	Contrast x-ray exam of colon		S	0277	2.2764	140.11	54.63	28.02

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
74283	Contrast x-ray exam of colon		S	0276	1.4519	89.37	34.97	17.87
74290	Contrast x-ray, gallbladder		S	0276	1.4519	89.37	34.97	17.87
74291	Contrast x-rays, gallbladder		S	0276	1.4519	89.37	34.97	17.87
74300	X-ray bile ducts/pancreas		X	0263	1.7120	105.38	23.77	21.08
74301	X-rays at surgery add-on		X	0263	1.7120	105.38	23.77	21.08
74305	X-ray bile ducts/pancreas		X	0263	1.7120	105.38	23.77	21.08
74320	Contrast x-ray of bile ducts		X	0264	2.9791	183.37	70.84	36.67
74327	X-ray bile stone removal		S	0296	2.7106	166.84	53.99	33.37
74328	X-ray bile duct endoscopy		N					
74329	X-ray for pancreas endoscopy		N					
74330	X-ray bile/panc endoscopy		N					
74340	X-ray guide for GI tube		X	0272	1.2985	79.92	31.64	15.98
74350	X-ray guide, stomach tube		X	0263	1.7120	105.38	23.77	21.08
74355	X-ray guide, intestinal tube		X	0263	1.7120	105.38	23.77	21.08
74360	X-ray guide, GI dilation	CH	S	0257	0.9770	60.14		12.03
74363	X-ray, bile duct dilation		S	0297	3.6483	224.56	89.82	44.91
74400	Contrst x-ray, urinary tract		S	0278	2.4721	152.16	60.84	30.43
74410	Contrst x-ray, urinary tract		S	0278	2.4721	152.16	60.84	30.43
74415	Contrst x-ray, urinary tract		S	0278	2.4721	152.16	60.84	30.43
74420	Contrst x-ray, urinary tract		S	0278	2.4721	152.16	60.84	30.43
74425	Contrst x-ray, urinary tract		S	0278	2.4721	152.16	60.84	30.43
74430	Contrast x-ray, bladder		S	0278	2.4721	152.16	60.84	30.43
74440	X-ray, male genital tract		S	0278	2.4721	152.16	60.84	30.43
74445	X-ray exam of penis		S	0278	2.4721	152.16	60.84	30.43
74450	X-ray, urethra/bladder		S	0278	2.4721	152.16	60.84	30.43
74455	X-ray, urethra/bladder		S	0278	2.4721	152.16	60.84	30.43
74470	X-ray exam of kidney lesion		X	0263	1.7120	105.38	23.77	21.08
74475	X-ray control, cath insert		S	0297	3.6483	224.56	89.82	44.91
74480	X-ray control, cath insert		S	0296	2.7106	166.84	53.99	33.37
74485	X-ray guide, GU dilation		S	0296	2.7106	166.84	53.99	33.37
74710	X-ray measurement of pelvis		X	0261	1.2515	77.03		15.41
74740	X-ray, female genital tract		X	0264	2.9791	183.37	70.84	36.67
74742	X-ray, fallopian tube		X	0264	2.9791	183.37	70.84	36.67
74775	X-ray exam of perineum		S	0278	2.4721	152.16	60.84	30.43
75552	Heart mri for morph w/o dye		S	0336	5.8500	360.07	139.68	72.01
75553	Heart mri for morph w/dye		S	0284	6.2589	385.24	148.40	77.05
75554	Cardiac MRI/function		S	0336	5.8500	360.07	139.68	72.01
75555	Cardiac MRI/limited study		S	0336	5.8500	360.07	139.68	72.01
75600	Contrast x-ray exam of aorta		S	0280	20.9479	1,289.36	353.85	257.87
75605	Contrast x-ray exam of aorta		S	0280	20.9479	1,289.36	353.85	257.87
75625	Contrast x-ray exam of aorta		S	0280	20.9479	1,289.36	353.85	257.87
75630	X-ray aorta, leg arteries		S	0280	20.9479	1,289.36	353.85	257.87
75635	Ct angio abdominal arteries		S	0662	4.9203	302.85	118.88	60.57
75650	Artery x-rays, head&neck		S	0280	20.9479	1,289.36	353.85	257.87
75658	Artery x-rays, arm		S	0279	9.6539	594.21	150.03	118.84
75660	Artery x-rays, head&neck		S	0668	6.3684	391.98	88.26	78.40
75662	Artery x-rays, head&neck		S	0280	20.9479	1,289.36	353.85	257.87
75665	Artery x-rays, head&neck		S	0280	20.9479	1,289.36	353.85	257.87
75671	Artery x-rays, head&neck		S	0280	20.9479	1,289.36	353.85	257.87
75676	Artery x-rays, neck		S	0280	20.9479	1,289.36	353.85	257.87
75680	Artery x-rays, neck		S	0280	20.9479	1,289.36	353.85	257.87
75685	Artery x-rays, spine		S	0280	20.9479	1,289.36	353.85	257.87
75705	Artery x-rays, spine		S	0668	6.3684	391.98	88.26	78.40
75710	Artery x-rays, arm/leg		S	0280	20.9479	1,289.36	353.85	257.87
75716	Artery x-rays, arms/legs		S	0280	20.9479	1,289.36	353.85	257.87
75722	Artery x-rays, kidney		S	0280	20.9479	1,289.36	353.85	257.87
75724	Artery x-rays, kidneys		S	0280	20.9479	1,289.36	353.85	257.87
75726	Artery x-rays, abdomen		S	0280	20.9479	1,289.36	353.85	257.87
75731	Artery x-rays, adrenal gland		S	0280	20.9479	1,289.36	353.85	257.87
75733	Artery x-rays, adrenals		S	0668	6.3684	391.98	88.26	78.40
75736	Artery x-rays, pelvis		S	0280	20.9479	1,289.36	353.85	257.87
75741	Artery x-rays, lung		S	0279	9.6539	594.21	150.03	118.84
75743	Artery x-rays, lungs		S	0280	20.9479	1,289.36	353.85	257.87
75746	Artery x-rays, lung		S	0279	9.6539	594.21	150.03	118.84
75756	Artery x-rays, chest		S	0279	9.6539	594.21	150.03	118.84
75774	Artery x-ray, each vessel		S	0279	9.6539	594.21	150.03	118.84
75790	Visualize A-V shunt		S	0279	9.6539	594.21	150.03	118.84
75801	Lymph vessel x-ray, arm/leg		X	0264	2.9791	183.37	70.84	36.67
75803	Lymph vessel x-ray,arms/legs		X	0264	2.9791	183.37	70.84	36.67
75805	Lymph vessel x-ray, trunk		X	0264	2.9791	183.37	70.84	36.67

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75807	Lymph vessel x-ray, trunk		X	0264	2.9791	183.37	70.84	36.67
75809	Nonvascular shunt, x-ray		X	0263	1.7120	105.38	23.77	21.08
75810	Vein x-ray, spleen/liver		S	0279	9.6539	594.21	150.03	118.84
75820	Vein x-ray, arm/leg		S	0668	6.3684	391.98	88.26	78.40
75822	Vein x-ray, arms/legs		S	0668	6.3684	391.98	88.26	78.40
75825	Vein x-ray, trunk		S	0279	9.6539	594.21	150.03	118.84
75827	Vein x-ray, chest		S	0279	9.6539	594.21	150.03	118.84
75831	Vein x-ray, kidney		S	0279	9.6539	594.21	150.03	118.84
75833	Vein x-ray, kidneys		S	0279	9.6539	594.21	150.03	118.84
75840	Vein x-ray, adrenal gland		S	0280	20.9479	1,289.36	353.85	257.87
75842	Vein x-ray, adrenal glands		S	0280	20.9479	1,289.36	353.85	257.87
75860	Vein x-ray, neck		S	0668	6.3684	391.98	88.26	78.40
75870	Vein x-ray, skull		S	0668	6.3684	391.98	88.26	78.40
75872	Vein x-ray, skull		S	0279	9.6539	594.21	150.03	118.84
75880	Vein x-ray, eye socket		S	0668	6.3684	391.98	88.26	78.40
75885	Vein x-ray, liver		S	0280	20.9479	1,289.36	353.85	257.87
75887	Vein x-ray, liver		S	0279	9.6539	594.21	150.03	118.84
75889	Vein x-ray, liver		S	0280	20.9479	1,289.36	353.85	257.87
75891	Vein x-ray, liver		S	0279	9.6539	594.21	150.03	118.84
75893	Venous sampling by catheter	CH	Q	0668	6.3684	391.98	88.26	78.40
75894	X-rays, transcath therapy	CH	S	0298	8.4904	522.59	209.02	104.52
75896	X-rays, transcath therapy	CH	S	0298	8.4904	522.59	209.02	104.52
75898	Follow-up angiography		X	0263	1.7120	105.38	23.77	21.08
75901	Remove cva device obstruct		X	0263	1.7120	105.38	23.77	21.08
75902	Remove cva lumen obstruct		X	0263	1.7120	105.38	23.77	21.08
75940	X-ray placement, vein filter	CH	S	0298	8.4904	522.59	209.02	104.52
75945	Intravascular us		S	0267	2.5166	154.90	60.80	30.98
75946	Intravascular us add-on		S	0266	1.5947	98.16	37.80	19.63
75960	Transcath iv stent rs&i		S	0668	6.3684	391.98	88.26	78.40
75961	Retrieval, broken catheter		S	0668	6.3684	391.98	88.26	78.40
75962	Repair arterial blockage		S	0668	6.3684	391.98	88.26	78.40
75964	Repair artery blockage, each		S	0668	6.3684	391.98	88.26	78.40
75966	Repair arterial blockage		S	0668	6.3684	391.98	88.26	78.40
75968	Repair artery blockage, each		S	0668	6.3684	391.98	88.26	78.40
75970	Vascular biopsy		S	0668	6.3684	391.98	88.26	78.40
75978	Repair venous blockage		S	0668	6.3684	391.98	88.26	78.40
75980	Contrast xray exam bile duct		S	0297	3.6483	224.56	89.82	44.91
75982	Contrast xray exam bile duct		S	0297	3.6483	224.56	89.82	44.91
75984	Xray control catheter change		X	0263	1.7120	105.38	23.77	21.08
75989	Abscess drainage under x-ray		N					
75992	Atherectomy, x-ray exam	CH	S	0668	6.3684	391.98	88.26	78.40
75993	Atherectomy, x-ray exam	CH	S	0668	6.3684	391.98	88.26	78.40
75994	Atherectomy, x-ray exam	CH	S	0668	6.3684	391.98	88.26	78.40
75995	Atherectomy, x-ray exam	CH	S	0668	6.3684	391.98	88.26	78.40
75996	Atherectomy, x-ray exam	CH	S	0668	6.3684	391.98	88.26	78.40
75998	Fluoroguide for vein device		N					
76000	Fluoroscope examination		X	0272	1.2985	79.92	31.64	15.98
76001	Fluoroscope exam, extensive		N					
76003	Needle localization by x-ray		N					
76005	Fluoroguide for spine inject		N					
76006	X-ray stress view		X	0260	0.7276	44.78		8.96
76010	X-ray, nose to rectum		X	0260	0.7276	44.78		8.96
76012	Percut vertebroplasty fluor		S	0274	2.6182	161.15	64.46	32.23
76013	Percut vertebroplasty, ct		S	0274	2.6182	161.15	64.46	32.23
76020	X-rays for bone age		X	0260	0.7276	44.78		8.96
76040	X-rays, bone evaluation	CH	X	0260	0.7276	44.78		8.96
76061	X-rays, bone survey		X	0261	1.2515	77.03		15.41
76062	X-rays, bone survey		X	0261	1.2515	77.03		15.41
76065	X-rays, bone evaluation	CH	X	0260	0.7276	44.78		8.96
76066	Joint survey, single view		X	0260	0.7276	44.78		8.96
76070	Ct bone density, axial		S	0288	1.2005	73.89		14.78
76071	Ct bone density, peripheral		S	0282	1.5552	95.72	37.92	19.14
76075	Dxa bone density, axial		S	0288	1.2005	73.89		14.78
76076	Dxa bone density/peripheral		S	0665	0.5569	34.28		6.86
76077	Dxa bone density/v-fracture		X	0260	0.7276	44.78		8.96
76078	Radiographic absorptiometry	CH	X	0261	1.2515	77.03		15.41
76080	X-ray exam of fistula		X	0263	1.7120	105.38	23.77	21.08
76086	X-ray of mammary duct		X	0263	1.7120	105.38	23.77	21.08
76088	X-ray of mammary ducts		X	0263	1.7120	105.38	23.77	21.08
76095	Stereotactic breast biopsy		X	0264	2.9791	183.37	70.84	36.67

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76096	X-ray of needle wire, breast		X	0263	1.7120	105.38	23.77	21.08
76098	X-ray exam, breast specimen		X	0260	0.7276	44.78		8.96
76100	X-ray exam of body section		X	0261	1.2515	77.03		15.41
76101	Complex body section x-ray		X	0263	1.7120	105.38	23.77	21.08
76102	Complex body section x-rays		X	0264	2.9791	183.37	70.84	36.67
76120	Cine/video x-rays		X	0272	1.2985	79.92	31.64	15.98
76125	Cine/video x-rays add-on		X	0260	0.7276	44.78		8.96
76150	X-ray exam, dry process		X	0260	0.7276	44.78		8.96
76350	Special x-ray contrast study		N					
76355	Ct scan for localization		S	0283	4.1858	257.64	102.17	51.53
76360	Ct scan for needle biopsy		S	0283	4.1858	257.64	102.17	51.53
76362	Ct guide for tissue ablation		S	0333	5.0020	307.88	121.52	61.58
76370	Ct scan for therapy guide		S	0282	1.5552	95.72	37.92	19.14
76376	3d render w/o postprocess		X	0340	0.6211	38.23		7.65
76377	3d rendering w/postprocess		S	0282	1.5552	95.72	37.92	19.14
76380	CAT scan follow-up study		S	0282	1.5552	95.72	37.92	19.14
76393	Mr guidance for needle place		S	0335	4.6629	287.01	114.80	57.40
76394	Mri for tissue ablation		S	0335	4.6629	287.01	114.80	57.40
76400	Magnetic image, bone marrow		S	0335	4.6629	287.01	114.80	57.40
76496	Fluoroscopic procedure		X	0272	1.2985	79.92	31.64	15.98
76497	Ct procedure		S	0282	1.5552	95.72	37.92	19.14
76498	Mri procedure		S	0335	4.6629	287.01	114.80	57.40
76499	Radiographic procedure		X	0260	0.7276	44.78		8.96
76506	Echo exam of head		S	0265	1.0145	62.44	23.63	12.49
76510	Ophth us, b&quant a		S	0266	1.5947	98.16	37.80	19.63
76511	Ophth us, quant a only		S	0266	1.5947	98.16	37.80	19.63
76512	Ophth us, b w/non-quant a		S	0266	1.5947	98.16	37.80	19.63
76513	Echo exam of eye, water bath		S	0266	1.5947	98.16	37.80	19.63
76514	Echo exam of eye, thickness		X	0340	0.6211	38.23		7.65
76516	Echo exam of eye		S	0265	1.0145	62.44	23.63	12.49
76519	Echo exam of eye		S	0266	1.5947	98.16	37.80	19.63
76529	Echo exam of eye		S	0265	1.0145	62.44	23.63	12.49
76536	Us exam of head and neck		S	0266	1.5947	98.16	37.80	19.63
76604	Us exam, chest, b-scan	CH	S	0265	1.0145	62.44	23.63	12.49
76645	Us exam, breast(s)		S	0265	1.0145	62.44	23.63	12.49
76700	Us exam, abdom, complete		S	0266	1.5947	98.16	37.80	19.63
76705	Echo exam of abdomen		S	0266	1.5947	98.16	37.80	19.63
76770	Us exam abdo back wall, comp		S	0266	1.5947	98.16	37.80	19.63
76775	Us exam abdo back wall, lim		S	0266	1.5947	98.16	37.80	19.63
76778	Us exam kidney transplant		S	0266	1.5947	98.16	37.80	19.63
76800	Us exam, spinal canal		S	0266	1.5947	98.16	37.80	19.63
76801	Ob us < 14 wks, single fetus		S	0266	1.5947	98.16	37.80	19.63
76802	Ob us < 14 wks, add'l fetus		S	0265	1.0145	62.44	23.63	12.49
76805	Ob us >/= 14 wks, sngl fetus		S	0266	1.5947	98.16	37.80	19.63
76810	Ob us >/= 14 wks, addl fetus		S	0266	1.5947	98.16	37.80	19.63
76811	Ob us, detailed, sngl fetus		S	0267	2.5166	154.90	60.80	30.98
76812	Ob us, detailed, addl fetus	CH	S	0265	1.0145	62.44	23.63	12.49
76815	Ob us, limited, fetus(s)		S	0265	1.0145	62.44	23.63	12.49
76816	Ob us, follow-up, per fetus		S	0265	1.0145	62.44	23.63	12.49
76817	Transvaginal us, obstetric	CH	S	0265	1.0145	62.44	23.63	12.49
76818	Fetal biophys profile w/nst		S	0266	1.5947	98.16	37.80	19.63
76819	Fetal biophys profil w/o nst		S	0266	1.5947	98.16	37.80	19.63
76820	Umbilical artery echo		S	0096	1.5727	96.80	38.13	19.36
76821	Middle cerebral artery echo		S	0096	1.5727	96.80	38.13	19.36
76825	Echo exam of fetal heart	CH	S	0697	1.6002	98.49	35.99	19.70
76826	Echo exam of fetal heart		S	0697	1.6002	98.49	35.99	19.70
76827	Echo exam of fetal heart	CH	S	0697	1.6002	98.49	35.99	19.70
76828	Echo exam of fetal heart		S	0697	1.6002	98.49	35.99	19.70
76830	Transvaginal us, non-ob		S	0266	1.5947	98.16	37.80	19.63
76831	Echo exam, uterus		S	0267	2.5166	154.90	60.80	30.98
76856	Us exam, pelvic, complete		S	0266	1.5947	98.16	37.80	19.63
76857	Us exam, pelvic, limited		S	0265	1.0145	62.44	23.63	12.49
76870	Us exam, scrotum		S	0266	1.5947	98.16	37.80	19.63
76872	Us, transrectal		S	0266	1.5947	98.16	37.80	19.63
76873	Echograp trans r, pros study		S	0266	1.5947	98.16	37.80	19.63
76880	Us exam, extremity		S	0266	1.5947	98.16	37.80	19.63
76885	Us exam infant hips, dynamic		S	0265	1.0145	62.44	23.63	12.49
76886	Us exam infant hips, static	CH	S	0265	1.0145	62.44	23.63	12.49
76930	Echo guide, cardiocentesis		S	0268	1.1967	73.66		14.73
76932	Echo guide for heart biopsy	CH	S	0309	2.1284	131.01		26.20

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76936	Echo guide for artery repair	CH	S	0309	2.1284	131.01		26.20
76937	Us guide, vascular access		N					
76940	Us guide, tissue ablation		S	0268	1.1967	73.66		14.73
76941	Echo guide for transfusion		S	0268	1.1967	73.66		14.73
76942	Echo guide for biopsy		S	0268	1.1967	73.66		14.73
76945	Echo guide, villus sampling		S	0268	1.1967	73.66		14.73
76946	Echo guide for amniocentesis		S	0268	1.1967	73.66		14.73
76948	Echo guide, ova aspiration	CH	S	0309	2.1284	131.01		26.20
76950	Echo guidance radiotherapy		S	0268	1.1967	73.66		14.73
76965	Echo guidance radiotherapy	CH	S	0309	2.1284	131.01		26.20
76970	Ultrasound exam follow-up		S	0265	1.0145	62.44	23.63	12.49
76975	GI endoscopic ultrasound		S	0266	1.5947	98.16	37.80	19.63
76977	Us bone density measure		X	0340	0.6211	38.23		7.65
76986	Ultrasound guide intraoper		S	0266	1.5947	98.16	37.80	19.63
76999	Echo examination procedure		S	0265	1.0145	62.44	23.63	12.49
77280	Set radiation therapy field		X	0304	1.6062	98.86	39.54	19.77
77285	Set radiation therapy field		X	0305	4.0232	247.63	91.38	49.53
77290	Set radiation therapy field		X	0305	4.0232	247.63	91.38	49.53
77295	Set radiation therapy field		X	0310	14.0578	865.27	325.27	173.05
77299	Radiation therapy planning		X	0304	1.6062	98.86	39.54	19.77
77300	Radiation therapy dose plan		X	0304	1.6062	98.86	39.54	19.77
77301	Radiotherapy dose plan, imrt		X	0310	14.0578	865.27	325.27	173.05
77305	Teletx isodose plan simple		X	0304	1.6062	98.86	39.54	19.77
77310	Teletx isodose plan intermed		X	0305	4.0232	247.63	91.38	49.53
77315	Teletx isodose plan complex		X	0305	4.0232	247.63	91.38	49.53
77321	Special teletx port plan		X	0305	4.0232	247.63	91.38	49.53
77326	Brachytx isodose calc simp		X	0304	1.6062	98.86	39.54	19.77
77327	Brachytx isodose calc interm		X	0305	4.0232	247.63	91.38	49.53
77328	Brachytx isodose plan compl		X	0305	4.0232	247.63	91.38	49.53
77331	Special radiation dosimetry		X	0304	1.6062	98.86	39.54	19.77
77332	Radiation treatment aid(s)		X	0303	2.9637	182.42	66.95	36.48
77333	Radiation treatment aid(s)		X	0303	2.9637	182.42	66.95	36.48
77334	Radiation treatment aid(s)		X	0303	2.9637	182.42	66.95	36.48
77336	Radiation physics consult		X	0304	1.6062	98.86	39.54	19.77
77370	Radiation physics consult		X	0304	1.6062	98.86	39.54	19.77
77399	External radiation dosimetry		X	0304	1.6062	98.86	39.54	19.77
77401	Radiation treatment delivery		S	0300	1.5004	92.35		18.47
77402	Radiation treatment delivery		S	0300	1.5004	92.35		18.47
77403	Radiation treatment delivery		S	0300	1.5004	92.35		18.47
77404	Radiation treatment delivery		S	0300	1.5004	92.35		18.47
77406	Radiation treatment delivery		S	0300	1.5004	92.35		18.47
77407	Radiation treatment delivery		S	0300	1.5004	92.35		18.47
77408	Radiation treatment delivery		S	0300	1.5004	92.35		18.47
77409	Radiation treatment delivery		S	0300	1.5004	92.35		18.47
77411	Radiation treatment delivery		S	0301	2.2670	139.54		27.91
77412	Radiation treatment delivery		S	0301	2.2670	139.54		27.91
77413	Radiation treatment delivery		S	0301	2.2670	139.54		27.91
77414	Radiation treatment delivery		S	0301	2.2670	139.54		27.91
77416	Radiation treatment delivery		S	0301	2.2670	139.54		27.91
77417	Radiology port film(s)		X	0260	0.7276	44.78		8.96
77418	Radiation tx delivery, imrt		S	0412	5.5021	338.66		67.73
77421	Stereoscopic x-ray guidance	CH	S	0257	0.9770	60.14		12.03
77422	Neutron beam tx, simple		S	0301	2.2670	139.54		27.91
77423	Neutron beam tx, complex		S	0301	2.2670	139.54		27.91
77470	Special radiation treatment		S	0299	6.0322	371.29		74.26
77520	Proton trmt, simple w/o comp		S	0664	18.4698	1,136.83		227.37
77522	Proton trmt, simple w/comp		S	0664	18.4698	1,136.83		227.37
77523	Proton trmt, intermediate		S	0667	22.0972	1,360.10		272.02
77525	Proton treatment, complex		S	0667	22.0972	1,360.10		272.02
77600	Hyperthermia treatment		S	0314	3.6583	225.17	66.65	45.03
77605	Hyperthermia treatment		S	0314	3.6583	225.17	66.65	45.03
77610	Hyperthermia treatment		S	0314	3.6583	225.17	66.65	45.03
77615	Hyperthermia treatment		S	0314	3.6583	225.17	66.65	45.03
77620	Hyperthermia treatment		S	0314	3.6583	225.17	66.65	45.03
77750	Infuse radioactive materials		S	0301	2.2670	139.54		27.91
77761	Apply intrcav radiat simple		S	0312	5.0185	308.89		61.78
77762	Apply intrcav radiat interm		S	0312	5.0185	308.89		61.78
77763	Apply intrcav radiat compl		S	0312	5.0185	308.89		61.78
77776	Apply interstit radiat simpl		S	0312	5.0185	308.89		61.78
77777	Apply interstit radiat inter		S	0312	5.0185	308.89		61.78

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77778	Apply interstit radiat compl		S	0651	16.6585	1,025.35		205.07
77781	High intensity brachytherapy		S	0313	13.3939	824.41		164.88
77782	High intensity brachytherapy		S	0313	13.3939	824.41		164.88
77783	High intensity brachytherapy		S	0313	13.3939	824.41		164.88
77784	High intensity brachytherapy		S	0313	13.3939	824.41		164.88
77789	Apply surface radiation		S	0300	1.5004	92.35		18.47
77790	Radiation handling		N					
77799	Radium/radioisotope therapy	CH	S	0312	5.0185	308.89		61.78
78000	Thyroid, single uptake		S	0389	1.4072	86.61	33.98	17.32
78001	Thyroid, multiple uptakes		S	0389	1.4072	86.61	33.98	17.32
78003	Thyroid suppress/stimul		S	0392	2.0849	128.33	51.33	25.67
78006	Thyroid imaging with uptake		S	0390	2.3732	146.07	58.42	29.21
78007	Thyroid image, mult uptakes		S	0391	2.7556	169.61	66.18	33.92
78010	Thyroid imaging		S	0390	2.3732	146.07	58.42	29.21
78011	Thyroid imaging with flow		S	0390	2.3732	146.07	58.42	29.21
78015	Thyroid met imaging		S	0406	3.9386	242.42	96.96	48.48
78016	Thyroid met imaging/studies		S	0406	3.9386	242.42	96.96	48.48
78018	Thyroid met imaging, body		S	0406	3.9386	242.42	96.96	48.48
78020	Thyroid met uptake		S	0399	1.5282	94.06	35.80	18.81
78070	Parathyroid nuclear imaging		S	0391	2.7556	169.61	66.18	33.92
78075	Adrenal nuclear imaging		S	0391	2.7556	169.61	66.18	33.92
78099	Endocrine nuclear procedure		S	0390	2.3732	146.07	58.42	29.21
78102	Bone marrow imaging, ltd		S	0400	3.9304	241.92	93.22	48.38
78103	Bone marrow imaging, mult		S	0400	3.9304	241.92	93.22	48.38
78104	Bone marrow imaging, body		S	0400	3.9304	241.92	93.22	48.38
78110	Plasma volume, single		S	0393	3.5902	220.98	82.04	44.20
78111	Plasma volume, multiple		S	0393	3.5902	220.98	82.04	44.20
78120	Red cell mass, single		S	0393	3.5902	220.98	82.04	44.20
78121	Red cell mass, multiple		S	0393	3.5902	220.98	82.04	44.20
78122	Blood volume		S	0393	3.5902	220.98	82.04	44.20
78130	Red cell survival study		S	0393	3.5902	220.98	82.04	44.20
78135	Red cell survival kinetics		S	0393	3.5902	220.98	82.04	44.20
78140	Red cell sequestration		S	0393	3.5902	220.98	82.04	44.20
78185	Spleen imaging		S	0400	3.9304	241.92	93.22	48.38
78190	Platelet survival, kinetics		S	0392	2.0849	128.33	51.33	25.67
78191	Platelet survival		S	0392	2.0849	128.33	51.33	25.67
78195	Lymph system imaging		S	0400	3.9304	241.92	93.22	48.38
78199	Blood/lymph nuclear exam		S	0400	3.9304	241.92	93.22	48.38
78201	Liver imaging		S	0394	4.4705	275.16	102.61	55.03
78202	Liver imaging with flow		S	0394	4.4705	275.16	102.61	55.03
78205	Liver imaging (3D)		S	0394	4.4705	275.16	102.61	55.03
78206	Liver image (3d) with flow		S	0394	4.4705	275.16	102.61	55.03
78215	Liver and spleen imaging		S	0394	4.4705	275.16	102.61	55.03
78216	Liver&spleen image/flow		S	0394	4.4705	275.16	102.61	55.03
78220	Liver function study		S	0394	4.4705	275.16	102.61	55.03
78223	Hepatobiliary imaging		S	0394	4.4705	275.16	102.61	55.03
78230	Salivary gland imaging		S	0395	3.6937	227.35	89.73	45.47
78231	Serial salivary imaging		S	0395	3.6937	227.35	89.73	45.47
78232	Salivary gland function exam		S	0395	3.6937	227.35	89.73	45.47
78258	Esophageal motility study		S	0395	3.6937	227.35	89.73	45.47
78261	Gastric mucosa imaging		S	0395	3.6937	227.35	89.73	45.47
78262	Gastroesophageal reflux exam		S	0395	3.6937	227.35	89.73	45.47
78264	Gastric emptying study		S	0395	3.6937	227.35	89.73	45.47
78270	Vit B-12 absorption exam		S	0392	2.0849	128.33	51.33	25.67
78271	Vit b-12 absrp exam, int fac		S	0392	2.0849	128.33	51.33	25.67
78272	Vit B-12 absorp, combined		S	0392	2.0849	128.33	51.33	25.67
78278	Acute GI blood loss imaging		S	0395	3.6937	227.35	89.73	45.47
78282	GI protein loss exam		S	0395	3.6937	227.35	89.73	45.47
78290	Meckel's divert exam		S	0395	3.6937	227.35	89.73	45.47
78291	Leveen/shunt patency exam		S	0395	3.6937	227.35	89.73	45.47
78299	GI nuclear procedure		S	0395	3.6937	227.35	89.73	45.47
78300	Bone imaging, limited area		S	0396	4.0166	247.23	95.02	49.45
78305	Bone imaging, multiple areas		S	0396	4.0166	247.23	95.02	49.45
78306	Bone imaging, whole body		S	0396	4.0166	247.23	95.02	49.45
78315	Bone imaging, 3 phase		S	0396	4.0166	247.23	95.02	49.45
78320	Bone imaging (3D)		S	0396	4.0166	247.23	95.02	49.45
78350	Bone mineral, single photon		X	0260	0.7276	44.78		8.96
78399	Musculoskeletal nuclear exam		S	0396	4.0166	247.23	95.02	49.45
78414	Non-imaging heart function		S	0398	4.2511	261.66	100.06	52.33
78428	Cardiac shunt imaging		S	0398	4.2511	261.66	100.06	52.33

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78445	Vascular flow imaging		S	0397	2.2521	138.62	49.58	27.72
78456	Acute venous thrombus image		S	0397	2.2521	138.62	49.58	27.72
78457	Venous thrombosis imaging		S	0397	2.2521	138.62	49.58	27.72
78458	Ven thrombosis images, bilat		S	0397	2.2521	138.62	49.58	27.72
78459	Heart muscle imaging (PET)	CH	S	0307	11.6773	718.75	287.49	143.75
78460	Heart muscle blood, single		S	0398	4.2511	261.66	100.06	52.33
78461	Heart muscle blood, multiple		S	0377	6.7443	415.12	158.84	83.02
78464	Heart image (3d), single		S	0398	4.2511	261.66	100.06	52.33
78465	Heart image (3d), multiple		S	0377	6.7443	415.12	158.84	83.02
78466	Heart infarct image		S	0398	4.2511	261.66	100.06	52.33
78468	Heart infarct image (ef)		S	0398	4.2511	261.66	100.06	52.33
78469	Heart infarct image (3D)		S	0398	4.2511	261.66	100.06	52.33
78472	Gated heart, planar, single		S	0398	4.2511	261.66	100.06	52.33
78473	Gated heart, multiple		S	0376	4.9770	306.34	119.77	61.27
78478	Heart wall motion add-on		S	0399	1.5282	94.06	35.80	18.81
78480	Heart function add-on		S	0399	1.5282	94.06	35.80	18.81
78481	Heart first pass, single		S	0398	4.2511	261.66	100.06	52.33
78483	Heart first pass, multiple		S	0376	4.9770	306.34	119.77	61.27
78491	Heart image (pet), single	CH	S	0307	11.6773	718.75	287.49	143.75
78492	Heart image (pet), multiple		S	0307	11.6773	718.75	287.49	143.75
78494	Heart image, spect		S	0398	4.2511	261.66	100.06	52.33
78496	Heart first pass add-on		S	0399	1.5282	94.06	35.80	18.81
78499	Cardiovascular nuclear exam		S	0398	4.2511	261.66	100.06	52.33
78580	Lung perfusion imaging		S	0401	3.2013	197.04	78.81	39.41
78584	Lung V/Q image single breath		S	0378	5.2084	320.58	128.23	64.12
78585	Lung V/Q imaging		S	0378	5.2084	320.58	128.23	64.12
78586	Aerosol lung image, single		S	0401	3.2013	197.04	78.81	39.41
78587	Aerosol lung image, multiple		S	0401	3.2013	197.04	78.81	39.41
78588	Perfusion lung image		S	0378	5.2084	320.58	128.23	64.12
78591	Vent image, 1 breath, 1 proj		S	0401	3.2013	197.04	78.81	39.41
78593	Vent image, 1 proj, gas		S	0401	3.2013	197.04	78.81	39.41
78594	Vent image, mult proj, gas		S	0401	3.2013	197.04	78.81	39.41
78596	Lung differential function		S	0378	5.2084	320.58	128.23	64.12
78599	Respiratory nuclear exam		S	0401	3.2013	197.04	78.81	39.41
78600	Brain imaging, ltd static		S	0402	4.8596	299.11	119.64	59.82
78601	Brain imaging, ltd w/flow		S	0402	4.8596	299.11	119.64	59.82
78605	Brain imaging, complete		S	0402	4.8596	299.11	119.64	59.82
78606	Brain imaging, compl w/flow		S	0402	4.8596	299.11	119.64	59.82
78607	Brain imaging (3D)		S	0402	4.8596	299.11	119.64	59.82
78608	Brain imaging (PET)	CH	S	0308	14.0093	862.29		172.46
78610	Brain flow imaging only		S	0402	4.8596	299.11	119.64	59.82
78615	Cerebral vascular flow image		S	0402	4.8596	299.11	119.64	59.82
78630	Cerebrospinal fluid scan		S	0403	3.4867	214.61	83.35	42.92
78635	CSF ventriculography		S	0403	3.4867	214.61	83.35	42.92
78645	CSF shunt evaluation		S	0403	3.4867	214.61	83.35	42.92
78647	Cerebrospinal fluid scan		S	0403	3.4867	214.61	83.35	42.92
78650	CSF leakage imaging		S	0403	3.4867	214.61	83.35	42.92
78660	Nuclear exam of tear flow		S	0403	3.4867	214.61	83.35	42.92
78699	Nervous system nuclear exam		S	0402	4.8596	299.11	119.64	59.82
78700	Kidney imaging, static		S	0404	3.4235	210.72	84.28	42.14
78701	Kidney imaging with flow		S	0404	3.4235	210.72	84.28	42.14
78704	Imaging renogram		S	0404	3.4235	210.72	84.28	42.14
78707	Kidney flow/function image		S	0404	3.4235	210.72	84.28	42.14
78708	Kidney flow/function image		S	0405	4.1056	252.70	98.77	50.54
78709	Kidney flow/function image		S	0405	4.1056	252.70	98.77	50.54
78710	Kidney imaging (3D)		S	0404	3.4235	210.72	84.28	42.14
78715	Renal vascular flow exam		S	0404	3.4235	210.72	84.28	42.14
78725	Kidney function study		S	0389	1.4072	86.61	33.98	17.32
78730	Urinary bladder retention		X	0340	0.6211	38.23		7.65
78740	Ureteral reflux study		S	0404	3.4235	210.72	84.28	42.14
78760	Testicular imaging		S	0404	3.4235	210.72	84.28	42.14
78761	Testicular imaging/flow		S	0404	3.4235	210.72	84.28	42.14
78799	Genitourinary nuclear exam		S	0404	3.4235	210.72	84.28	42.14
78800	Tumor imaging, limited area		S	0406	3.9386	242.42	96.96	48.48
78801	Tumor imaging, mult areas		S	0406	3.9386	242.42	96.96	48.48
78802	Tumor imaging, whole body		S	0406	3.9386	242.42	96.96	48.48
78803	Tumor imaging (3D)		S	0406	3.9386	242.42	96.96	48.48
78804	Tumor imaging, whole body	CH	S	0408	4.9998	307.74		61.55
78805	Abscess imaging, ltd area		S	0406	3.9386	242.42	96.96	48.48
78806	Abscess imaging, whole body	CH	S	0408	4.9998	307.74		61.55

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78807	Nuclear localization/abscess		S	0406	3.9386	242.42	96.96	48.48
78811	Tumor imaging (pet), limited	CH	S	0308	14.0093	862.29		172.46
78812	Tumor image (pet)/skul-thigh	CH	S	0308	14.0093	862.29		172.46
78813	Tumor image (pet) full body	CH	S	0308	14.0093	862.29		172.46
78814	Tumor image pet/ct, limited	CH	S	0308	14.0093	862.29		172.46
78815	Tumorimage pet/ct skul-thigh	CH	S	0308	14.0093	862.29		172.46
78816	Tumor image pet/ct full body	CH	S	0308	14.0093	862.29		172.46
78890	Nuclear medicine data proc		N					
78891	Nuclear med data proc		N					
78999	Nuclear diagnostic exam		S	0389	1.4072	86.61	33.98	17.32
79005	Nuclear rx, oral admin		S	0407	3.1506	193.92	77.56	38.78
79101	Nuclear rx, iv admin		S	0407	3.1506	193.92	77.56	38.78
79200	Nuclear rx, intracav admin	CH	S	0413	5.1026	314.07		62.81
79300	Nuclr rx, interstit colloid		S	0407	3.1506	193.92	77.56	38.78
79403	Hematopoietic nuclear tx	CH	S	0413	5.1026	314.07		62.81
79440	Nuclear rx, intra-articular	CH	S	0413	5.1026	314.07		62.81
79445	Nuclear rx, intra-arterial		S	0407	3.1506	193.92	77.56	38.78
79999	Nuclear medicine therapy		S	0407	3.1506	193.92	77.56	38.78
80103	Drug analysis, tissue prep		N					
80500	Lab pathology consultation		X	0433	0.2571	15.82	5.93	3.16
80502	Lab pathology consultation		X	0342	0.0813	5.00	2.00	1.00
85097	Bone marrow interpretation		X	0343	0.5309	32.68	10.84	6.54
85396	Clotting assay, whole blood		N					
86077	Physician blood bank service		X	0433	0.2571	15.82	5.93	3.16
86078	Physician blood bank service		X	0343	0.5309	32.68	10.84	6.54
86079	Physician blood bank service		X	0433	0.2571	15.82	5.93	3.16
86485	Skin test, candida		X	0341	0.0914	5.63	2.25	1.13
86490	Coccidioidomycosis skin test		X	0341	0.0914	5.63	2.25	1.13
86510	Histoplasmosis skin test		X	0341	0.0914	5.63	2.25	1.13
86580	TB intradermal test		X	0341	0.0914	5.63	2.25	1.13
86850	RBC antibody screen		X	0345	0.2218	13.65	2.87	2.73
86860	RBC antibody elution		X	0346	0.3494	21.51	4.39	4.30
86870	RBC antibody identification		X	0346	0.3494	21.51	4.39	4.30
86880	Coombs test, direct		X	0409	0.1237	7.61	2.20	1.52
86885	Coombs test, indirect, qual		X	0409	0.1237	7.61	2.20	1.52
86886	Coombs test, indirect, titer		X	0409	0.1237	7.61	2.20	1.52
86890	Autologous blood process		X	0347	0.7394	45.51	11.24	9.10
86891	Autologous blood, op salvage		X	0346	0.3494	21.51	4.39	4.30
86900	Blood typing, ABO		X	0409	0.1237	7.61	2.20	1.52
86901	Blood typing, Rh (D)		X	0409	0.1237	7.61	2.20	1.52
86903	Blood typing, antigen screen		X	0345	0.2218	13.65	2.87	2.73
86904	Blood typing, patient serum		X	0346	0.3494	21.51	4.39	4.30
86905	Blood typing, RBC antigens		X	0345	0.2218	13.65	2.87	2.73
86906	Blood typing, Rh phenotype		X	0345	0.2218	13.65	2.87	2.73
86920	Compatibility test, spin		X	0346	0.3494	21.51	4.39	4.30
86921	Compatibility test, incubate		X	0345	0.2218	13.65	2.87	2.73
86922	Compatibility test, antiglob		X	0346	0.3494	21.51	4.39	4.30
86923	Compatibility test, electric		X	0345	0.2218	13.65	2.87	2.73
86927	Plasma, fresh frozen		X	0345	0.2218	13.65	2.87	2.73
86930	Frozen blood prep		X	0347	0.7394	45.51	11.24	9.10
86931	Frozen blood thaw		X	0347	0.7394	45.51	11.24	9.10
86932	Frozen blood freeze/thaw		X	0347	0.7394	45.51	11.24	9.10
86945	Blood product/irradiation		X	0345	0.2218	13.65	2.87	2.73
86950	Leukacyte transfusion		X	0345	0.2218	13.65	2.87	2.73
86960	Vol reduction of blood/prod		X	0345	0.2218	13.65	2.87	2.73
86965	Pooling blood platelets	CH	X	0346	0.3494	21.51	4.39	4.30
86970	RBC pretreatment		X	0345	0.2218	13.65	2.87	2.73
86971	RBC pretreatment		X	0345	0.2218	13.65	2.87	2.73
86972	RBC pretreatment		X	0346	0.3494	21.51	4.39	4.30
86975	RBC pretreatment, serum	CH	X	0346	0.3494	21.51	4.39	4.30
86976	RBC pretreatment, serum		X	0345	0.2218	13.65	2.87	2.73
86977	RBC pretreatment, serum	CH	X	0346	0.3494	21.51	4.39	4.30
86978	RBC pretreatment, serum	CH	X	0346	0.3494	21.51	4.39	4.30
86985	Split blood or products		X	0345	0.2218	13.65	2.87	2.73
86999	Transfusion procedure		X	0345	0.2218	13.65	2.87	2.73
88104	Cytopathology, fluids		X	0433	0.2571	15.82	5.93	3.16
88106	Cytopathology, fluids		X	0433	0.2571	15.82	5.93	3.16
88107	Cytopathology, fluids		X	0433	0.2571	15.82	5.93	3.16
88108	Cytopath, concentrate tech		X	0433	0.2571	15.82	5.93	3.16
88112	Cytopath, cell enhance tech		X	0343	0.5309	32.68	10.84	6.54

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88125	Forensic cytopathology	CH	X	0433	0.2571	15.82	5.93	3.16
88141	Cytopath, c/v, interpret		N					
88160	Cytopath smear, other source		X	0433	0.2571	15.82	5.93	3.16
88161	Cytopath smear, other source		X	0433	0.2571	15.82	5.93	3.16
88162	Cytopath smear, other source		X	0433	0.2571	15.82	5.93	3.16
88172	Cytopathology eval of fna		X	0343	0.5309	32.68	10.84	6.54
88173	Cytopath eval, fna, report		X	0343	0.5309	32.68	10.84	6.54
88182	Cell marker study	CH	X	0343	0.5309	32.68	10.84	6.54
88184	Flowcytometry/tc, 1 marker	CH	X	0433	0.2571	15.82	5.93	3.16
88185	Flowcytometry/tc, add-on	CH	X	0433	0.2571	15.82	5.93	3.16
88187	Flowcytometry/read, 2–8		X	0433	0.2571	15.82	5.93	3.16
88188	Flowcytometry/read, 9–15		X	0433	0.2571	15.82	5.93	3.16
88189	Flowcytometry/read, 16&>		X	0343	0.5309	32.68	10.84	6.54
88299	Cytogenetic study		X	0342	0.0813	5.00	2.00	1.00
88300	Surgical path, gross		X	0433	0.2571	15.82	5.93	3.16
88302	Tissue exam by pathologist		X	0433	0.2571	15.82	5.93	3.16
88304	Tissue exam by pathologist		X	0343	0.5309	32.68	10.84	6.54
88305	Tissue exam by pathologist		X	0343	0.5309	32.68	10.84	6.54
88307	Tissue exam by pathologist		X	0344	0.8107	49.90	15.66	9.98
88309	Tissue exam by pathologist		X	0344	0.8107	49.90	15.66	9.98
88311	Decalcify tissue	CH	X	0433	0.2571	15.82	5.93	3.16
88312	Special stains		X	0433	0.2571	15.82	5.93	3.16
88313	Special stains		X	0433	0.2571	15.82	5.93	3.16
88314	Histochemical stain		X	0342	0.0813	5.00	2.00	1.00
88318	Chemical histochemistry		X	0433	0.2571	15.82	5.93	3.16
88319	Enzyme histochemistry		X	0343	0.5309	32.68	10.84	6.54
88321	Microslide consultation		X	0433	0.2571	15.82	5.93	3.16
88323	Microslide consultation		X	0343	0.5309	32.68	10.84	6.54
88325	Comprehensive review of data		X	0344	0.8107	49.90	15.66	9.98
88329	Path consult introp		X	0433	0.2571	15.82	5.93	3.16
88331	Path consult intraop, 1 bloc		X	0343	0.5309	32.68	10.84	6.54
88332	Path consult intraop, add'l		X	0433	0.2571	15.82	5.93	3.16
88333	Intraop cyto path consult, 1		X	0343	0.5309	32.68	10.84	6.54
88334	Intraop cyto path consult, 2		X	0433	0.2571	15.82	5.93	3.16
88342	Immunohistochemistry		X	0343	0.5309	32.68	10.84	6.54
88346	Immunofluorescent study		X	0343	0.5309	32.68	10.84	6.54
88347	Immunofluorescent study		X	0343	0.5309	32.68	10.84	6.54
88348	Electron microscopy		X	0661	2.6066	160.44	64.17	32.09
88349	Scanning electron microscopy		X	0661	2.6066	160.44	64.17	32.09
88355	Analysis, skeletal muscle		X	0343	0.5309	32.68	10.84	6.54
88356	Analysis, nerve		X	0344	0.8107	49.90	15.66	9.98
88358	Analysis, tumor		X	0344	0.8107	49.90	15.66	9.98
88360	Tumor immunohistochem/manual	CH	X	0343	0.5309	32.68	10.84	6.54
88361	Tumor immunohistochem/comput		X	0344	0.8107	49.90	15.66	9.98
88362	Nerve teasing preparations		X	0344	0.8107	49.90	15.66	9.98
88365	Insitu hybridization (fish)		X	0344	0.8107	49.90	15.66	9.98
88367	Insitu hybridization, auto		X	0344	0.8107	49.90	15.66	9.98
88368	Insitu hybridization, manual		X	0344	0.8107	49.90	15.66	9.98
88380	Microdissection		N					
88384	Eval molecular probes, 11–50		X	0433	0.2571	15.82	5.93	3.16
88385	Eval molecul probes, 51–250		X	0343	0.5309	32.68	10.84	6.54
88386	Eval molecul probes, 251–500		X	0344	0.8107	49.90	15.66	9.98
89049	Chct for mal hyperthermia		X	0343	0.5309	32.68	10.84	6.54
89100	Sample intestinal contents		X	0360	1.3789	84.87	33.88	16.97
89105	Sample intestinal contents		X	0360	1.3789	84.87	33.88	16.97
89130	Sample stomach contents		X	0360	1.3789	84.87	33.88	16.97
89132	Sample stomach contents		X	0360	1.3789	84.87	33.88	16.97
89135	Sample stomach contents		X	0360	1.3789	84.87	33.88	16.97
89136	Sample stomach contents		X	0360	1.3789	84.87	33.88	16.97
89140	Sample stomach contents		X	0360	1.3789	84.87	33.88	16.97
89141	Sample stomach contents		X	0360	1.3789	84.87	33.88	16.97
89220	Sputum specimen collection		X	0343	0.5309	32.68	10.84	6.54
89230	Collect sweat for test		X	0433	0.2571	15.82	5.93	3.16
89250	Cultr oocyte/embryo <4 days		X	0348	0.8928	54.95		10.99
89251	Cultr oocyte/embryo <4 days		X	0348	0.8928	54.95		10.99
89253	Embryo hatching		X	0348	0.8928	54.95		10.99
89254	Oocyte identification		X	0348	0.8928	54.95		10.99
89255	Prepare embryo for transfer		X	0348	0.8928	54.95		10.99
89257	Sperm identification		X	0348	0.8928	54.95		10.99
89258	Cryopreservation; embryo(s)		X	0348	0.8928	54.95		10.99

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
89259	Cryopreservation, sperm		X	0348	0.8928	54.95		10.99
89260	Sperm isolation, simple		X	0348	0.8928	54.95		10.99
89261	Sperm isolation, complex		X	0348	0.8928	54.95		10.99
89264	Identify sperm tissue		X	0348	0.8928	54.95		10.99
89268	Insemination of oocytes		X	0348	0.8928	54.95		10.99
89272	Extended culture of oocytes		X	0348	0.8928	54.95		10.99
89280	Assist oocyte fertilization		X	0348	0.8928	54.95		10.99
89281	Assist oocyte fertilization		X	0348	0.8928	54.95		10.99
89290	Biopsy, oocyte polar body		X	0348	0.8928	54.95		10.99
89291	Biopsy, oocyte polar body		X	0348	0.8928	54.95		10.99
89335	Cryopreserve testicular tiss		X	0348	0.8928	54.95		10.99
89342	Storage/year; embryo(s)		X	0348	0.8928	54.95		10.99
89343	Storage/year; sperm/semen		X	0348	0.8928	54.95		10.99
89344	Storage/year; reprod tissue		X	0348	0.8928	54.95		10.99
89346	Storage/year; oocyte(s)		X	0348	0.8928	54.95		10.99
89352	Thawing cryopresrved; embryo		X	0348	0.8928	54.95		10.99
89353	Thawing cryopresrved; sperm		X	0348	0.8928	54.95		10.99
89354	Thaw cryoprsvrd; reprod tiss		X	0348	0.8928	54.95		10.99
89356	Thawing cryopresrved; oocyte		X	0348	0.8928	54.95		10.99
90296	Diphtheria antitoxin		N					
90371	Hep b ig, im		K	1630		118.61		23.72
90375	Rabies ig, im/sc		K	9133		63.98		12.80
90376	Rabies ig, heat treated		K	9134		68.58		13.72
90385	Rh ig, minidose, im		N					
90393	Vaccina ig, im		N					
90396	Varicella-zoster ig, im		K	9135		149.08		29.82
90471	Immunization admin	CH	S	0437	0.4107	25.28		5.06
90472	Immunization admin, each add	CH	S	0436	0.1769	10.89		2.18
90473	Immune admin oral/nasal	CH	S	0436	0.1769	10.89		2.18
90474	Immune admin oral/nasal addl	CH	S	0436	0.1769	10.89		2.18
90476	Adenovirus vaccine, type 4	CH	N					
90477	Adenovirus vaccine, type 7		N					
90581	Anthrax vaccine, sc	CH	N					
90585	Bcg vaccine, percut		K	9137		115.46		23.09
90632	Hep a vaccine, adult im		N					
90633	Hep a vacc, ped/adol, 2 dose		N					
90634	Hep a vacc, ped/adol, 3 dose		N					
90636	Hep a/hep b vacc, adult im	CH	N					
90645	Hib vaccine, hboc, im		N					
90646	Hib vaccine, prp-d, im		N					
90647	Hib vaccine, prp-omp, im		N					
90648	Hib vaccine, prp-t, im		N					
90665	Lyme disease vaccine, im	CH	N					
90675	Rabies vaccine, im		K	9139		155.25		31.05
90676	Rabies vaccine, id		K	9140		118.49		23.70
90680	Rotovirus vacc 3 dose, oral		N					
90690	Typhoid vaccine, oral		N					
90691	Typhoid vaccine, im		N					
90692	Typhoid vaccine, h-p, sc/id		N					
90693	Typhoid vaccine, akd, sc		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		K	9141		44.62		8.92
90710	Mmrv vaccine, sc		N					
90712	Oral poliovirus vaccine		N					
90713	Poliovirus, ipv, sc/im		N					
90714	Td vaccine no prsrv >/= 7 im	CH	N					
90715	Tdap vaccine >7 im		N					
90716	Chicken pox vaccine, sc		K	9142		66.84		13.37
90717	Yellow fever vaccine, sc	CH	N					
90718	Td vaccine > 7, im		N					
90719	Diphtheria vaccine, im		N					
90720	Dtp/hib vaccine, im	CH	K	3032		68.91		13.78

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90721	Dtap/hib vaccine, im		N					
90725	Cholera vaccine, injectable		N					
90727	Plague vaccine, im	CH	K	0744		150.00		30.00
90733	Meningococcal vaccine, sc		K	9143		84.46		16.89
90734	Meningococcal vaccine, im		K	9145		143.12		28.62
90735	Encephalitis vaccine, sc		K	9144		99.15		19.83
90749	Vaccine toxoid		N					
90772	Ther/proph/diag inj, sc/im	CH	S	0437	0.4107	25.28		5.06
90773	Ther/proph/diag inj, ia	CH	S	0438	0.7892	48.58		9.72
90779	Ther/prop/diag inj/inf proc	CH	S	0436	0.1769	10.89		2.18
90801	Psy dx interview		S	0323	1.7170	105.68		21.14
90802	Intac psy dx interview		S	0323	1.7170	105.68		21.14
90804	Psytx, office, 20–30 min		S	0322	1.1749	72.32		14.46
90805	Psytx, off, 20–30 min w/e&m		S	0322	1.1749	72.32		14.46
90806	Psytx, off, 45–50 min		S	0323	1.7170	105.68		21.14
90807	Psytx, off, 45–50 min w/e&m		S	0323	1.7170	105.68		21.14
90808	Psytx, office, 75–80 min		S	0323	1.7170	105.68		21.14
90809	Psytx, off, 75-80, w/e&m		S	0323	1.7170	105.68		21.14
90810	Intac psytx, off, 20–30 min		S	0322	1.1749	72.32		14.46
90811	Intac psytx, 20–30, w/e&m		S	0322	1.1749	72.32		14.46
90812	Intac psytx, off, 45–50 min		S	0323	1.7170	105.68		21.14
90813	Intac psytx, 45–50 min w/e&m		S	0323	1.7170	105.68		21.14
90814	Intac psytx, off, 75–80 min		S	0323	1.7170	105.68		21.14
90815	Intac psytx, 75–80 w/e&m		S	0323	1.7170	105.68		21.14
90816	Psytx, hosp, 20–30 min		S	0322	1.1749	72.32		14.46
90817	Psytx, hosp, 20–30 min w/e&m		S	0322	1.1749	72.32		14.46
90818	Psytx, hosp, 45–50 min		S	0323	1.7170	105.68		21.14
90819	Psytx, hosp, 45–50 min w/e&m		S	0323	1.7170	105.68		21.14
90821	Psytx, hosp, 75–80 min		S	0323	1.7170	105.68		21.14
90822	Psytx, hosp, 75–80 min w/e&m		S	0323	1.7170	105.68		21.14
90823	Intac psytx, hosp, 20–30 min		S	0322	1.1749	72.32		14.46
90824	Intac psytx, hsp 20–30 w/e&m		S	0322	1.1749	72.32		14.46
90826	Intac psytx, hosp, 45–50 min		S	0323	1.7170	105.68		21.14
90827	Intac psytx, hsp 45–50 w/e&m		S	0323	1.7170	105.68		21.14
90828	Intac psytx, hosp, 75–80 min		S	0323	1.7170	105.68		21.14
90829	Intac psytx, hsp 75–80 w/e&m		S	0323	1.7170	105.68		21.14
90845	Psychoanalysis		S	0323	1.7170	105.68		21.14
90846	Family psytx w/o patient		S	0324	2.2087	135.95		27.19
90847	Family psytx w/patient		S	0324	2.2087	135.95		27.19
90849	Multiple family group psytx		S	0325	1.0787	66.40	14.51	13.28
90853	Group psychotherapy		S	0325	1.0787	66.40	14.51	13.28
90857	Intac group psytx		S	0325	1.0787	66.40	14.51	13.28
90862	Medication management		X	0374	1.1509	70.84		14.17
90865	Narcosynthesis		S	0323	1.7170	105.68		21.14
90870	Electroconvulsive therapy		S	0320	5.5017	338.64	80.06	67.73
90880	Hypnotherapy		S	0323	1.7170	105.68		21.14
90885	Psy evaluation of records		N					
90887	Consultation with family		N					
90889	Preparation of report		N					
90899	Psychiatric service/therapy		S	0322	1.1749	72.32		14.46
90911	Biofeedback peri/uro/rectal		S	0321	1.3693	84.28	21.72	16.86
90935	Hemodialysis, one evaluation		S	0170	6.8096	419.14		83.83
90940	Hemodialysis access study		N					
90945	Dialysis, one evaluation		S	0170	6.8096	419.14		83.83
91000	Esophageal intubation		X	0361	3.9319	242.01	83.23	48.40
91010	Esophagus motility study		X	0361	3.9319	242.01	83.23	48.40
91011	Esophagus motility study		X	0361	3.9319	242.01	83.23	48.40
91012	Esophagus motility study		X	0361	3.9319	242.01	83.23	48.40
91020	Gastric motility studies		X	0361	3.9319	242.01	83.23	48.40
91022	Duodenal motility study		X	0361	3.9319	242.01	83.23	48.40
91030	Acid perfusion of esophagus		X	0361	3.9319	242.01	83.23	48.40
91034	Gastroesophageal reflux test		X	0361	3.9319	242.01	83.23	48.40
91035	G-esoph reflx tst w/electrod	CH	X	0361	3.9319	242.01	83.23	48.40
91037	Esoph imped function test		X	0361	3.9319	242.01	83.23	48.40
91038	Esoph imped funct test > 1h		X	0361	3.9319	242.01	83.23	48.40
91040	Esoph balloon distension tst		X	0360	1.3789	84.87	33.88	16.97
91052	Gastric analysis test		X	0361	3.9319	242.01	83.23	48.40
91055	Gastric intubation for smear		X	0360	1.3789	84.87	33.88	16.97
91060	Gastric saline load test		X	0360	1.3789	84.87	33.88	16.97
91065	Breath hydrogen test		X	0360	1.3789	84.87	33.88	16.97

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
91100	Pass intestine bleeding tube		X	0360	1.3789	84.87	33.88	16.97
91105	Gastric intubation treatment		X	0360	1.3789	84.87	33.88	16.97
91110	Gi tract capsule endoscopy		T	0142	9.3878	577.83	152.78	115.57
91120	Rectal sensation test	CH	T	0126	1.0844	66.75	16.40	13.35
91122	Anal pressure record	CH	T	0164	2.1159	130.24		26.05
91123	Irrigate fecal impaction		N					
91132	Electrogastrography		X	0360	1.3789	84.87	33.88	16.97
91133	Electrogastrography w/test		X	0360	1.3789	84.87	33.88	16.97
91299	Gastroenterology procedure		X	0360	1.3789	84.87	33.88	16.97
92002	Eye exam, new patient	CH	V	0605	1.0057	61.90		12.38
92004	Eye exam, new patient	CH	V	0606	1.3546	83.38		16.68
92012	Eye exam established pat	CH	V	0604	0.8083	49.75		9.95
92014	Eye exam&treatment	CH	V	0605	1.0057	61.90		12.38
92018	New eye exam&treatment		T	0699	13.9509	858.69		171.74
92019	Eye exam&treatment		T	0699	13.9509	858.69		171.74
92020	Special eye evaluation		S	0230	0.8126	50.02	14.97	10.00
92060	Special eye evaluation		S	0230	0.8126	50.02	14.97	10.00
92065	Orthoptic/pleoptic training	CH	S	0230	0.8126	50.02	14.97	10.00
92070	Fitting of contact lens		N					
92081	Visual field examination(s)		S	0230	0.8126	50.02	14.97	10.00
92082	Visual field examination(s)		S	0230	0.8126	50.02	14.97	10.00
92083	Visual field examination(s)		S	0230	0.8126	50.02	14.97	10.00
92100	Serial tonometry exam(s)		N					
92120	Tonography&eye evaluation		S	0230	0.8126	50.02	14.97	10.00
92130	Water provocation tonography		S	0230	0.8126	50.02	14.97	10.00
92135	Opthalmic dx imaging		S	0230	0.8126	50.02	14.97	10.00
92136	Ophthalmic biometry		S	0698	1.2244	75.36	16.52	15.07
92140	Glaucoma provocative tests	CH	S	0230	0.8126	50.02	14.97	10.00
92225	Special eye exam, initial	CH	S	0230	0.8126	50.02	14.97	10.00
92226	Special eye exam, subsequent	CH	S	0230	0.8126	50.02	14.97	10.00
92230	Eye exam with photos	CH	S	0231	2.1934	135.01		27.00
92235	Eye exam with photos		S	0231	2.1934	135.01		27.00
92240	Icg angiography		S	0231	2.1934	135.01		27.00
92250	Eye exam with photos		S	0230	0.8126	50.02	14.97	10.00
92260	Ophthalmoscopy/dynamometry	CH	S	0230	0.8126	50.02	14.97	10.00
92265	Eye muscle evaluation		S	0230	0.8126	50.02	14.97	10.00
92270	Electro-oculography		S	0230	0.8126	50.02	14.97	10.00
92275	Electroretinography		S	0231	2.1934	135.01		27.00
92283	Color vision examination		S	0230	0.8126	50.02	14.97	10.00
92284	Dark adaptation eye exam		S	0698	1.2244	75.36	16.52	15.07
92285	Eye photography		S	0230	0.8126	50.02	14.97	10.00
92286	Internal eye photography		S	0698	1.2244	75.36	16.52	15.07
92287	Internal eye photography		S	0698	1.2244	75.36	16.52	15.07
92311	Contact lens fitting		X	0362	0.5328	32.79		6.56
92312	Contact lens fitting		X	0362	0.5328	32.79		6.56
92313	Contact lens fitting		X	0362	0.5328	32.79		6.56
92315	Prescription of contact lens		X	0362	0.5328	32.79		6.56
92316	Prescription of contact lens		X	0362	0.5328	32.79		6.56
92317	Prescription of contact lens		X	0362	0.5328	32.79		6.56
92325	Modification of contact lens		X	0362	0.5328	32.79		6.56
92326	Replacement of contact lens		X	0362	0.5328	32.79		6.56
92352	Special spectacles fitting		X	0362	0.5328	32.79		6.56
92353	Special spectacles fitting		X	0362	0.5328	32.79		6.56
92354	Special spectacles fitting		X	0362	0.5328	32.79		6.56
92355	Special spectacles fitting		X	0362	0.5328	32.79		6.56
92358	Eye prosthesis service		X	0362	0.5328	32.79		6.56
92371	Repair&adjust spectacles		X	0362	0.5328	32.79		6.56
92499	Eye service or procedure		S	0230	0.8126	50.02	14.97	10.00
92502	Ear and throat examination		T	0251	2.3768	146.29		29.26
92504	Ear microscopy examination		N					
92511	Nasopharyngoscopy		T	0071	0.7572	46.61	11.03	9.32
92512	Nasal function studies		X	0363	0.8534	52.53	17.44	10.51
92516	Facial nerve function test		X	0660	1.4988	92.25	29.07	18.45
92520	Laryngeal function studies		X	0660	1.4988	92.25	29.07	18.45
92531	Spontaneous nystagmus study		N					
92532	Positional nystagmus test		N					
92533	Caloric vestibular test		N					
92534	Optokinetic nystagmus test		N					
92541	Spontaneous nystagmus test		X	0363	0.8534	52.53	17.44	10.51
92542	Positional nystagmus test		X	0363	0.8534	52.53	17.44	10.51

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92543	Caloric vestibular test		X	0660	1.4988	92.25	29.07	18.45
92544	Optokinetic nystagmus test		X	0363	0.8534	52.53	17.44	10.51
92545	Oscillating tracking test		X	0363	0.8534	52.53	17.44	10.51
92546	Sinusoidal rotational test		X	0660	1.4988	92.25	29.07	18.45
92547	Supplemental electrical test		X	0363	0.8534	52.53	17.44	10.51
92548	Posturography		X	0660	1.4988	92.25	29.07	18.45
92552	Pure tone audiometry, air		X	0364	0.4637	28.54	7.06	5.71
92553	Audiometry, air&bone		X	0365	1.2467	76.74	18.52	15.35
92555	Speech threshold audiometry		X	0364	0.4637	28.54	7.06	5.71
92556	Speech audiometry, complete		X	0364	0.4637	28.54	7.06	5.71
92557	Comprehensive hearing test		X	0365	1.2467	76.74	18.52	15.35
92561	Bekesy audiometry, diagnosis		X	0364	0.4637	28.54	7.06	5.71
92562	Loudness balance test		X	0364	0.4637	28.54	7.06	5.71
92563	Tone decay hearing test		X	0364	0.4637	28.54	7.06	5.71
92564	Sisi hearing test		X	0364	0.4637	28.54	7.06	5.71
92565	Stenger test, pure tone		X	0364	0.4637	28.54	7.06	5.71
92567	Tympanometry		X	0364	0.4637	28.54	7.06	5.71
92568	Acoustic refl threshold tst		X	0364	0.4637	28.54	7.06	5.71
92569	Acoustic reflex decay test		X	0364	0.4637	28.54	7.06	5.71
92571	Filtered speech hearing test		X	0364	0.4637	28.54	7.06	5.71
92572	Staggered spondaic word test		X	0366	1.8175	111.87	26.14	22.37
92573	Lombard test		X	0364	0.4637	28.54	7.06	5.71
92575	Sensorineural acuity test		X	0364	0.4637	28.54	7.06	5.71
92576	Synthetic sentence test		X	0364	0.4637	28.54	7.06	5.71
92577	Stenger test, speech		X	0366	1.8175	111.87	26.14	22.37
92579	Visual audiometry (vra)		X	0365	1.2467	76.74	18.52	15.35
92582	Conditioning play audiometry		X	0365	1.2467	76.74	18.52	15.35
92583	Select picture audiometry		X	0364	0.4637	28.54	7.06	5.71
92584	Electrocochleography		X	0660	1.4988	92.25	29.07	18.45
92585	Auditor evoke potent, compre		S	0216	2.6729	164.52		32.90
92586	Auditor evoke potent, limit		S	0218	1.1993	73.82		14.76
92587	Evoked auditory test		X	0363	0.8534	52.53	17.44	10.51
92588	Evoked auditory test		X	0660	1.4988	92.25	29.07	18.45
92596	Ear protector evaluation		X	0364	0.4637	28.54	7.06	5.71
92601	Cochlear implt f/up exam < 7		X	0366	1.8175	111.87	26.14	22.37
92602	Reprogram cochlear implt < 7		X	0366	1.8175	111.87	26.14	22.37
92603	Cochlear implt f/up exam 7 >		X	0366	1.8175	111.87	26.14	22.37
92604	Reprogram cochlear implt 7 >		X	0366	1.8175	111.87	26.14	22.37
92620	Auditory function, 60 min		X	0365	1.2467	76.74	18.52	15.35
92621	Auditory function, + 15 min		N					
92625	Tinnitus assessment		X	0365	1.2467	76.74	18.52	15.35
92626	Eval aud rehab status		X	0365	1.2467	76.74	18.52	15.35
92627	Eval aud status rehab add-on		N					
92700	Ent procedure/service		X	0364	0.4637	28.54	7.06	5.71
92950	Heart/lung resuscitation cpr		S	0094	2.4630	151.60	46.29	30.32
92953	Temporary external pacing		S	0094	2.4630	151.60	46.29	30.32
92960	Cardioversion electric, ext		S	0679	5.5435	341.21	95.30	68.24
92961	Cardioversion, electric, int		S	0679	5.5435	341.21	95.30	68.24
92973	Percut coronary thrombectomy		T	0088	37.9652	2,336.80	655.22	467.36
92974	Cath place, cardio brachytx		T	0103	17.0436	1,049.05	223.63	209.81
92977	Dissolve clot, heart vessel		T	0676	2.0612	126.87		25.37
92978	Intravasc us, heart add-on		S	0670	29.7322	1,830.05	536.10	366.01
92979	Intravasc us, heart add-on		S	0416	32.2182	1,983.06		396.61
92980	Insert intracoronary stent		T	0104	87.9808	5,415.31		1,083.06
92981	Insert intracoronary stent		T	0104	87.9808	5,415.31		1,083.06
92982	Coronary artery dilation		T	0083	57.4937	3,538.79		707.76
92984	Coronary artery dilation		T	0083	57.4937	3,538.79		707.76
92986	Revision of aortic valve		T	0083	57.4937	3,538.79		707.76
92987	Revision of mitral valve		T	0083	57.4937	3,538.79		707.76
92990	Revision of pulmonary valve		T	0083	57.4937	3,538.79		707.76
92995	Coronary atherectomy		T	0082	76.2006	4,690.22	1,008.90	938.04
92996	Coronary atherectomy add-on		T	0082	76.2006	4,690.22	1,008.90	938.04
92997	Pul art balloon repr, percut		T	0081	42.8894	2,639.89		527.98
92998	Pul art balloon repr, percut		T	0081	42.8894	2,639.89		527.98
93005	Electrocardiogram, tracing		S	0099	0.3835	23.60		4.72
93012	Transmission of ecg		N					
93017	Cardiovascular stress test		X	0100	2.5352	156.04	41.44	31.21
93024	Cardiac drug stress test		X	0100	2.5352	156.04	41.44	31.21
93025	Microvolt t-wave assess		X	0100	2.5352	156.04	41.44	31.21
93041	Rhythm ECG, tracing		S	0099	0.3835	23.60		4.72

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93225	ECG monitor/record, 24 hrs		X	0097	1.0245	63.06	23.79	12.61
93226	ECG monitor/report, 24 hrs		X	0097	1.0245	63.06	23.79	12.61
93231	Ecg monitor/record, 24 hrs		X	0097	1.0245	63.06	23.79	12.61
93232	ECG monitor/report, 24 hrs		X	0097	1.0245	63.06	23.79	12.61
93236	ECG monitor/report, 24 hrs		X	0097	1.0245	63.06	23.79	12.61
93270	ECG recording		X	0097	1.0245	63.06	23.79	12.61
93271	Ecg/monitoring and analysis		X	0097	1.0245	63.06	23.79	12.61
93278	ECG/signal-averaged		S	0099	0.3835	23.60		4.72
93303	Echo transthoracic		S	0269	3.2432	199.62	75.60	39.92
93304	Echo transthoracic		S	0697	1.6002	98.49	35.99	19.70
93307	Echo exam of heart		S	0269	3.2432	199.62	75.60	39.92
93308	Echo exam of heart		S	0697	1.6002	98.49	35.99	19.70
93312	Echo transesophageal		S	0270	6.2689	385.86	141.32	77.17
93313	Echo transesophageal		S	0270	6.2689	385.86	141.32	77.17
93314	Echo transesophageal		N					
93315	Echo transesophageal		S	0270	6.2689	385.86	141.32	77.17
93316	Echo transesophageal		S	0270	6.2689	385.86	141.32	77.17
93317	Echo transesophageal		N					
93318	Echo transesophageal intraop		S	0270	6.2689	385.86	141.32	77.17
93320	Doppler echo exam, heart	CH	S	0697	1.6002	98.49	35.99	19.70
93321	Doppler echo exam, heart		S	0697	1.6002	98.49	35.99	19.70
93325	Doppler color flow add-on		S	0697	1.6002	98.49	35.99	19.70
93350	Echo transthoracic		S	0269	3.2432	199.62	75.60	39.92
93501	Right heart catheterization		T	0080	37.1008	2,283.59	838.92	456.72
93503	Insert/place heart catheter		T	0103	17.0436	1,049.05	223.63	209.81
93505	Biopsy of heart lining		T	0103	17.0436	1,049.05	223.63	209.81
93508	Cath placement, angiography		T	0080	37.1008	2,283.59	838.92	456.72
93510	Left heart catheterization		T	0080	37.1008	2,283.59	838.92	456.72
93511	Left heart catheterization		T	0080	37.1008	2,283.59	838.92	456.72
93514	Left heart catheterization		T	0080	37.1008	2,283.59	838.92	456.72
93524	Left heart catheterization		T	0080	37.1008	2,283.59	838.92	456.72
93526	Rt&Lt heart catheters		T	0080	37.1008	2,283.59	838.92	456.72
93527	Rt&Lt heart catheters		T	0080	37.1008	2,283.59	838.92	456.72
93528	Rt&Lt heart catheters		T	0080	37.1008	2,283.59	838.92	456.72
93529	Rt, lt heart catheterization		T	0080	37.1008	2,283.59	838.92	456.72
93530	Rt heart cath, congenital		T	0080	37.1008	2,283.59	838.92	456.72
93531	R&l heart cath, congenital		T	0080	37.1008	2,283.59	838.92	456.72
93532	R&l heart cath, congenital		T	0080	37.1008	2,283.59	838.92	456.72
93533	R&l heart cath, congenital		T	0080	37.1008	2,283.59	838.92	456.72
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		S	0670	29.7322	1,830.05	536.10	366.01
93572	Heart flow reserve measure		S	0416	32.2182	1,983.06		396.61
93580	Transcath closure of asd		T	0434	87.3424	5,376.01		1,075.20
93581	Transcath closure of vsd		T	0434	87.3424	5,376.01		1,075.20
93600	Bundle of His recording		T	0087	32.8298	2,020.71		404.14
93602	Intra-atrial recording		T	0087	32.8298	2,020.71		404.14
93603	Right ventricular recording		T	0087	32.8298	2,020.71		404.14
93609	Map tachycardia, add-on		T	0087	32.8298	2,020.71		404.14
93610	Intra-atrial pacing		T	0087	32.8298	2,020.71		404.14
93612	Intraventricular pacing		T	0087	32.8298	2,020.71		404.14
93613	Electrophys map 3d, add-on		T	0087	32.8298	2,020.71		404.14
93615	Esophageal recording		T	0087	32.8298	2,020.71		404.14
93616	Esophageal recording		T	0087	32.8298	2,020.71		404.14
93618	Heart rhythm pacing		T	0087	32.8298	2,020.71		404.14
93619	Electrophysiology evaluation		T	0085	34.7086	2,136.35		427.27
93620	Electrophysiology evaluation		T	0085	34.7086	2,136.35		427.27
93621	Electrophysiology evaluation		T	0085	34.7086	2,136.35		427.27
93622	Electrophysiology evaluation		T	0085	34.7086	2,136.35		427.27
93623	Stimulation, pacing heart		T	0087	32.8298	2,020.71		404.14
93624	Electrophysiologic study		T	0085	34.7086	2,136.35		427.27

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93631	Heart pacing, mapping		T	0087	32.8298	2,020.71		404.14
93640	Evaluation heart device	CH	N					
93641	Electrophysiology evaluation	CH	N					
93642	Electrophysiology evaluation		S	0084	9.9197	610.57		122.11
93650	Ablate heart dysrhythm focus		T	0086	47.1472	2,901.96	812.36	580.39
93651	Ablate heart dysrhythm focus		T	0086	47.1472	2,901.96	812.36	580.39
93652	Ablate heart dysrhythm focus		T	0086	47.1472	2,901.96	812.36	580.39
93660	Tilt table evaluation		S	0101	4.3122	265.42	100.24	53.08
93662	Intracardiac ecg (ice)		S	0670	29.7322	1,830.05	536.10	366.01
93701	Bioimpedance, thoracic		S	0099	0.3835	23.60		4.72
93721	Plethysmography tracing		X	0368	0.9568	58.89	22.77	11.78
93724	Analyze pacemaker system		S	0690	0.3628	22.33	8.67	4.47
93727	Analyze ilr system		S	0690	0.3628	22.33	8.67	4.47
93731	Analyze pacemaker system		S	0690	0.3628	22.33	8.67	4.47
93732	Analyze pacemaker system		S	0690	0.3628	22.33	8.67	4.47
93733	Telephone analy, pacemaker		S	0690	0.3628	22.33	8.67	4.47
93734	Analyze pacemaker system		S	0690	0.3628	22.33	8.67	4.47
93735	Analyze pacemaker system		S	0690	0.3628	22.33	8.67	4.47
93736	Telephonic analy, pacemaker		S	0690	0.3628	22.33	8.67	4.47
93740	Temperature gradient studies		X	0368	0.9568	58.89	22.77	11.78
93741	Analyze ht pace device sngl		S	0689	0.5400	33.24		6.65
93742	Analyze ht pace device sngl		S	0689	0.5400	33.24		6.65
93743	Analyze ht pace device dual		S	0689	0.5400	33.24		6.65
93744	Analyze ht pace device dual		S	0689	0.5400	33.24		6.65
93745	Set-up cardiovert-defibrill		S	0689	0.5400	33.24		6.65
93770	Measure venous pressure		N					
93786	Ambulatory BP recording		X	0097	1.0245	63.06	23.79	12.61
93788	Ambulatory BP analysis		X	0097	1.0245	63.06	23.79	12.61
93797	Cardiac rehab		S	0095	0.5792	35.65	13.86	7.13
93798	Cardiac rehab/monitor		S	0095	0.5792	35.65	13.86	7.13
93799	Cardiovascular procedure	CH	X	0097	1.0245	63.06	23.79	12.61
93875	Extracranial study		S	0096	1.5727	96.80	38.13	19.36
93880	Extracranial study		S	0267	2.5166	154.90	60.80	30.98
93882	Extracranial study		S	0267	2.5166	154.90	60.80	30.98
93886	Intracranial study		S	0267	2.5166	154.90	60.80	30.98
93888	Intracranial study	CH	S	0265	1.0145	62.44	23.63	12.49
93890	Tcd, vasoreactivity study		S	0266	1.5947	98.16	37.80	19.63
93892	Tcd, emboli detect w/o inj		S	0266	1.5947	98.16	37.80	19.63
93893	Tcd, emboli detect w/inj		S	0266	1.5947	98.16	37.80	19.63
93922	Extremity study		S	0096	1.5727	96.80	38.13	19.36
93923	Extremity study		S	0096	1.5727	96.80	38.13	19.36
93924	Extremity study		S	0096	1.5727	96.80	38.13	19.36
93925	Lower extremity study		S	0267	2.5166	154.90	60.80	30.98
93926	Lower extremity study		S	0266	1.5947	98.16	37.80	19.63
93930	Upper extremity study		S	0267	2.5166	154.90	60.80	30.98
93931	Upper extremity study		S	0266	1.5947	98.16	37.80	19.63
93965	Extremity study		S	0096	1.5727	96.80	38.13	19.36
93970	Extremity study		S	0267	2.5166	154.90	60.80	30.98
93971	Extremity study		S	0266	1.5947	98.16	37.80	19.63
93975	Vascular study		S	0267	2.5166	154.90	60.80	30.98
93976	Vascular study		S	0267	2.5166	154.90	60.80	30.98
93978	Vascular study		S	0266	1.5947	98.16	37.80	19.63
93979	Vascular study		S	0266	1.5947	98.16	37.80	19.63
93980	Penile vascular study		S	0267	2.5166	154.90	60.80	30.98
93981	Penile vascular study		S	0266	1.5947	98.16	37.80	19.63
93990	Doppler flow testing		S	0266	1.5947	98.16	37.80	19.63
94010	Breathing capacity test		X	0368	0.9568	58.89	22.77	11.78
94014	Patient recorded spirometry		X	0367	0.6253	38.49	14.64	7.70
94015	Patient recorded spirometry		X	0367	0.6253	38.49	14.64	7.70
94060	Evaluation of wheezing		X	0368	0.9568	58.89	22.77	11.78
94070	Evaluation of wheezing		X	0369	2.8329	174.37	44.18	34.87
94150	Vital capacity test		X	0367	0.6253	38.49	14.64	7.70
94200	Lung function test (MBC/MVV)		X	0367	0.6253	38.49	14.64	7.70
94240	Residual lung capacity		X	0368	0.9568	58.89	22.77	11.78
94250	Expired gas collection		X	0367	0.6253	38.49	14.64	7.70
94260	Thoracic gas volume	CH	X	0368	0.9568	58.89	22.77	11.78
94350	Lung nitrogen washout curve	CH	X	0368	0.9568	58.89	22.77	11.78
94360	Measure airflow resistance		X	0367	0.6253	38.49	14.64	7.70
94370	Breath airway closing volume		X	0367	0.6253	38.49	14.64	7.70
94375	Respiratory flow volume loop		X	0367	0.6253	38.49	14.64	7.70

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
94400	CO2 breathing response curve		X	0367	0.6253	38.49	14.64	7.70
94450	Hypoxia response curve		X	0368	0.9568	58.89	22.77	11.78
94452	Hast w/report		X	0368	0.9568	58.89	22.77	11.78
94453	Hast w/oxygen titrate	CH	X	0367	0.6253	38.49	14.64	7.70
94620	Pulmonary stress test/simple		X	0368	0.9568	58.89	22.77	11.78
94621	Pulm stress test/complex		X	0369	2.8329	174.37	44.18	34.87
94640	Airway inhalation treatment		S	0077	0.3383	20.82	7.74	4.16
94642	Aerosol inhalation treatment		S	0078	1.0381	63.90	14.55	12.78
94656	Initial ventilator mgmt		S	0079	2.7732	170.69		34.14
94657	Continued ventilator mgmt		S	0079	2.7732	170.69		34.14
94660	Pos airway pressure, CPAP		S	0068	1.3718	84.44	29.48	16.89
94662	Neg press ventilation, cnp		S	0079	2.7732	170.69		34.14
94664	Evaluate pt use of inhaler		S	0077	0.3383	20.82	7.74	4.16
94667	Chest wall manipulation		S	0077	0.3383	20.82	7.74	4.16
94668	Chest wall manipulation		S	0077	0.3383	20.82	7.74	4.16
94680	Exhaled air analysis, o2		X	0367	0.6253	38.49	14.64	7.70
94681	Exhaled air analysis, o2/co2		X	0368	0.9568	58.89	22.77	11.78
94690	Exhaled air analysis	CH	X	0367	0.6253	38.49	14.64	7.70
94720	Monoxide diffusing capacity		X	0368	0.9568	58.89	22.77	11.78
94725	Membrane diffusion capacity		X	0368	0.9568	58.89	22.77	11.78
94750	Pulmonary compliance study	CH	X	0367	0.6253	38.49	14.64	7.70
94760	Measure blood oxygen level		N					
94761	Measure blood oxygen level		N					
94762	Measure blood oxygen level	CH	Q	0443	0.9939	61.18	24.47	12.24
94770	Exhaled carbon dioxide test		X	0367	0.6253	38.49	14.64	7.70
94772	Breath recording, infant		X	0369	2.8329	174.37	44.18	34.87
94799	Pulmonary service/procedure		X	0367	0.6253	38.49	14.64	7.70
95004	Percut allergy skin tests		X	0381	0.2151	13.24		2.65
95010	Percut allergy titrate test		X	0381	0.2151	13.24		2.65
95015	Id allergy titrate-drug/bug		X	0381	0.2151	13.24		2.65
95024	Id allergy test, drug/bug		X	0381	0.2151	13.24		2.65
95027	Id allergy titrate-airborne		X	0381	0.2151	13.24		2.65
95028	Id allergy test-delayed type		X	0381	0.2151	13.24		2.65
95044	Allergy patch tests		X	0381	0.2151	13.24		2.65
95052	Photo patch test		X	0381	0.2151	13.24		2.65
95056	Photosensitivity tests		X	0370	1.0769	66.28		13.26
95060	Eye allergy tests		X	0370	1.0769	66.28		13.26
95065	Nose allergy test		X	0381	0.2151	13.24		2.65
95070	Bronchial allergy tests		X	0369	2.8329	174.37	44.18	34.87
95071	Bronchial allergy tests		X	0369	2.8329	174.37	44.18	34.87
95075	Ingestion challenge test		X	0361	3.9319	242.01	83.23	48.40
95078	Provocative testing		X	0370	1.0769	66.28		13.26
95115	Immunotherapy, one injection	CH	S	0436	0.1769	10.89		2.18
95117	Immunotherapy injections	CH	S	0437	0.4107	25.28		5.06
95144	Antigen therapy services	CH	S	0437	0.4107	25.28		5.06
95145	Antigen therapy services	CH	S	0437	0.4107	25.28		5.06
95146	Antigen therapy services	CH	S	0437	0.4107	25.28		5.06
95147	Antigen therapy services	CH	S	0437	0.4107	25.28		5.06
95148	Antigen therapy services	CH	S	0437	0.4107	25.28		5.06
95149	Antigen therapy services	CH	S	0437	0.4107	25.28		5.06
95165	Antigen therapy services	CH	S	0437	0.4107	25.28		5.06
95170	Antigen therapy services	CH	S	0437	0.4107	25.28		5.06
95180	Rapid desensitization		X	0370	1.0769	66.28		13.26
95199	Allergy immunology services	CH	X	0381	0.2151	13.24		2.65
95250	Glucose monitoring, cont		X	0421	1.6486	101.47		20.29
95805	Multiple sleep latency test		S	0209	11.4847	706.89	268.73	141.38
95806	Sleep study, unattended		S	0213	2.3133	142.39	53.58	28.48
95807	Sleep study, attended		S	0209	11.4847	706.89	268.73	141.38
95808	Polysomnography, 1-3		S	0209	11.4847	706.89	268.73	141.38
95810	Polysomnography, 4 or more		S	0209	11.4847	706.89	268.73	141.38
95811	Polysomnography w/cpap		S	0209	11.4847	706.89	268.73	141.38
95812	Eeg, 41-60 minutes		S	0213	2.3133	142.39	53.58	28.48
95813	Eeg, over 1 hour		S	0213	2.3133	142.39	53.58	28.48
95816	Eeg, awake and drowsy		S	0213	2.3133	142.39	53.58	28.48
95819	Eeg, awake and asleep		S	0213	2.3133	142.39	53.58	28.48
95822	Eeg, coma or sleep only		S	0213	2.3133	142.39	53.58	28.48
95824	Eeg, cerebral death only		S	0214	1.2353	76.03	28.24	15.21
95827	Eeg, all night recording		S	0213	2.3133	142.39	53.58	28.48
95829	Surgery electrocorticogram		S	0214	1.2353	76.03	28.24	15.21
95857	Tensilon test		S	0218	1.1993	73.82		14.76

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95860	Muscle test, one limb		S	0218	1.1993	73.82		14.76
95861	Muscle test, 2 limbs		S	0218	1.1993	73.82		14.76
95863	Muscle test, 3 limbs		S	0218	1.1993	73.82		14.76
95864	Muscle test, 4 limbs		S	0218	1.1993	73.82		14.76
95865	Muscle test, larynx		S	0218	1.1993	73.82		14.76
95866	Muscle test, hemidiaphragm		S	0218	1.1993	73.82		14.76
95867	Muscle test cran nerv unilat		S	0218	1.1993	73.82		14.76
95868	Muscle test cran nerve bilat		S	0218	1.1993	73.82		14.76
95869	Muscle test, thor paraspinal		S	0215	0.5760	35.45		7.09
95870	Muscle test, nonparaspinal		S	0215	0.5760	35.45		7.09
95872	Muscle test, one fiber		S	0218	1.1993	73.82		14.76
95873	Guide nerv destr, elec stim		S	0215	0.5760	35.45		7.09
95874	Guide nerv destr, needle emg		S	0215	0.5760	35.45		7.09
95875	Limb exercise test		S	0215	0.5760	35.45		7.09
95900	Motor nerve conduction test		S	0215	0.5760	35.45		7.09
95903	Motor nerve conduction test		S	0215	0.5760	35.45		7.09
95904	Sense nerve conduction test		S	0215	0.5760	35.45		7.09
95920	Intraop nerve test add-on		S	0216	2.6729	164.52		32.90
95921	Autonomic nerv function test	CH	S	0215	0.5760	35.45		7.09
95922	Autonomic nerv function test	CH	S	0215	0.5760	35.45		7.09
95923	Autonomic nerv function test	CH	S	0215	0.5760	35.45		7.09
95925	Somatosensory testing		S	0216	2.6729	164.52		32.90
95926	Somatosensory testing		S	0216	2.6729	164.52		32.90
95927	Somatosensory testing		S	0216	2.6729	164.52		32.90
95928	C motor evoked, uppr limbs		S	0218	1.1993	73.82		14.76
95929	C motor evoked, lwr limbs		S	0218	1.1993	73.82		14.76
95930	Visual evoked potential test		S	0216	2.6729	164.52		32.90
95933	Blink reflex test		S	0215	0.5760	35.45		7.09
95934	H-reflex test		S	0215	0.5760	35.45		7.09
95936	H-reflex test		S	0215	0.5760	35.45		7.09
95937	Neuromuscular junction test	CH	S	0215	0.5760	35.45		7.09
95950	Ambulatory eeg monitoring		S	0209	11.4847	706.89	268.73	141.38
95951	EEG monitoring/videorecord		S	0209	11.4847	706.89	268.73	141.38
95953	EEG monitoring/computer		S	0209	11.4847	706.89	268.73	141.38
95954	EEG monitoring/giving drugs		S	0214	1.2353	76.03	28.24	15.21
95955	EEG during surgery		S	0213	2.3133	142.39	53.58	28.48
95956	Eeg monitoring, cable/radio		S	0209	11.4847	706.89	268.73	141.38
95957	EEG digital analysis		S	0214	1.2353	76.03	28.24	15.21
95958	EEG monitoring/function test		S	0213	2.3133	142.39	53.58	28.48
95961	Electrode stimulation, brain		S	0216	2.6729	164.52		32.90
95962	Electrode stim, brain add-on		S	0216	2.6729	164.52		32.90
95965	Meg, spontaneous	CH	S	0038	51.2627	3,155.27		631.05
95966	Meg, evoked, single	CH	S	0209	11.4847	706.89	268.73	141.38
95967	Meg, evoked, each add'l	CH	S	0209	11.4847	706.89	268.73	141.38
95970	Analyze neurostim, no prog		S	0218	1.1993	73.82		14.76
95971	Analyze neurostim, simple		S	0692	1.9519	120.14	30.16	24.03
95972	Analyze neurostim, complex		S	0692	1.9519	120.14	30.16	24.03
95973	Analyze neurostim, complex	CH	S	0663	1.0752	66.18	16.96	13.24
95974	Cranial neurostim, complex		S	0692	1.9519	120.14	30.16	24.03
95975	Cranial neurostim, complex		S	0692	1.9519	120.14	30.16	24.03
95978	Analyze neurostim brain/1h		S	0692	1.9519	120.14	30.16	24.03
95979	Analyz neurostim brain addon	CH	S	0663	1.0752	66.18	16.96	13.24
95990	Spin/brain pump refil&main		T	0125	2.2200	136.64		27.33
95991	Spin/brain pump refil&main		T	0125	2.2200	136.64		27.33
95999	Neurological procedure		S	0215	0.5760	35.45		7.09
96000	Motion analysis, video/3d		S	0216	2.6729	164.52		32.90
96001	Motion test w/ft press meas		S	0216	2.6729	164.52		32.90
96002	Dynamic surface emg		S	0218	1.1993	73.82		14.76
96003	Dynamic fine wire emg		S	0215	0.5760	35.45		7.09
96101	Psycho testing by psych/phys		X	0373	1.6262	100.09		20.02
96102	Psycho testing by technician		X	0382	2.7541	169.52	67.80	33.90
96103	Psycho testing admin by comp		X	0373	1.6262	100.09		20.02
96110	Developmental test, lim		X	0373	1.6262	100.09		20.02
96111	Developmental test, extend		X	0373	1.6262	100.09		20.02
96116	Neurobehavioral status exam		X	0373	1.6262	100.09		20.02
96118	Neuropsych tst by psych/phys		X	0373	1.6262	100.09		20.02
96119	Neuropsych testing by tech		X	0382	2.7541	169.52	67.80	33.90
96120	Neuropsych tst admin w/comp		X	0373	1.6262	100.09		20.02
96150	Assess hlth/behave, init		S	0432	0.6006	36.97		7.39
96151	Assess hlth/behave, subseq		S	0432	0.6006	36.97		7.39

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
96152	Intervene hlth/behave, indiv		S	0432	0.6006	36.97		7.39
96153	Intervene hlth/behave, group		S	0432	0.6006	36.97		7.39
96154	Interv hlth/behav, fam w/pt		S	0432	0.6006	36.97		7.39
96401	Chemo, anti-neopl, sq/im	CH	S	0438	0.7892	48.58		9.72
96402	Chemo hormon antineopl sq/im	CH	S	0438	0.7892	48.58		9.72
96405	Chemo intralesional, up to 7	CH	S	0438	0.7892	48.58		9.72
96406	Chemo intralesional over 7	CH	S	0438	0.7892	48.58		9.72
96416	Chemo prolong infuse w/pump	CH	S	0441	2.5071	154.31		30.86
96420	Chemo, ia, push tecnique	CH	S	0439	1.5841	97.50		19.50
96422	Chemo ia infusion up to 1 hr	CH	S	0441	2.5071	154.31		30.86
96423	Chemo ia infuse each addl hr	CH	S	0438	0.7892	48.58		9.72
96425	Chemotherapy,infusion method	CH	S	0441	2.5071	154.31		30.86
96440	Chemotherapy, intracavitary	CH	S	0439	1.5841	97.50		19.50
96445	Chemotherapy, intracavitary	CH	S	0439	1.5841	97.50		19.50
96450	Chemotherapy, into CNS	CH	S	0441	2.5071	154.31		30.86
96521	Refill/maint, portable pump	CH	S	0440	1.8285	112.55		22.51
96522	Refill/maint pump/resvr syst	CH	S	0440	1.8285	112.55		22.51
96523	Irrig drug delivery device	CH	Q	0624	0.5336	32.84	13.13	6.57
96542	Chemotherapy injection	CH	S	0438	0.7892	48.58		9.72
96549	Chemotherapy, unspecified	CH	S	0436	0.1769	10.89		2.18
96567	Photodynamic tx, skin		T	0016	2.6253	161.59	32.68	32.32
96570	Photodynamic tx, 30 min		T	0015	1.6062	98.86	20.13	19.77
96571	Photodynamic tx, addl 15 min		T	0015	1.6062	98.86	20.13	19.77
96900	Ultraviolet light therapy		S	0001	0.4896	30.14	7.00	6.03
96902	Trichogram		N					
96910	Photochemotherapy with UV–B		S	0001	0.4896	30.14	7.00	6.03
96912	Photochemotherapy with UV–A		S	0001	0.4896	30.14	7.00	6.03
96913	Photochemotherapy, UV–A or B		S	0683	2.6902	165.58		33.12
96920	Laser tx, skin < 250 sq cm		T	0013	1.0876	66.94		13.39
96921	Laser tx, skin 250–500 sq cm		T	0013	1.0876	66.94		13.39
96922	Laser tx, skin > 500 sq cm		T	0013	1.0876	66.94		13.39
96999	Dermatological procedure		T	0010	0.4829	29.72	8.14	5.94
97597	Active wound care/20 cm or <		T	0012	0.8076	49.71	10.30	9.94
97598	Active wound care > 20 cm		T	0013	1.0876	66.94		13.39
97602	Wound(s) care non-selective		X	0340	0.6211	38.23		7.65
97605	Neg press wound tx, < 50 cm		T	0012	0.8076	49.71	10.30	9.94
97606	Neg press wound tx, > 50 cm		T	0013	1.0876	66.94		13.39
98925	Osteopathic manipulation		S	0060	0.4904	30.18		6.04
98926	Osteopathic manipulation		S	0060	0.4904	30.18		6.04
98927	Osteopathic manipulation		S	0060	0.4904	30.18		6.04
98928	Osteopathic manipulation		S	0060	0.4904	30.18		6.04
98929	Osteopathic manipulation		S	0060	0.4904	30.18		6.04
98940	Chiropractic manipulation		S	0060	0.4904	30.18		6.04
98941	Chiropractic manipulation		S	0060	0.4904	30.18		6.04
98942	Chiropractic manipulation		S	0060	0.4904	30.18		6.04
99078	Group health education		N					
99091	Collect/review data from pt		N					
99143	Mod cs by same phys, < 5 yrs		N					
99144	Mod cs by same phys, 5 yrs +		N					
99145	Mod cs by same phys add-on		N					
99148	Mod cs diff phys < 5 yrs		N					
99149	Mod cs diff phys 5 yrs +		N					
99150	Mod cs diff phys add-on		N					
99170	Anogenital exam, child		T	0191	0.1501	9.24		1.85
99175	Induction of vomiting		N					
99185	Regional hypothermia		N					
99186	Total body hypothermia		N					
99195	Phlebotomy		X	0372	0.5814	35.79	10.09	7.16
99201	Office/outpatient visit, new	CH	B					
99202	Office/outpatient visit, new	CH	B					
99203	Office/outpatient visit, new	CH	B					
99204	Office/outpatient visit, new	CH	B					
99205	Office/outpatient visit, new	CH	B					
99211	Office/outpatient visit, est	CH	B					
99212	Office/outpatient visit, est	CH	B					
99213	Office/outpatient visit, est	CH	B					
99214	Office/outpatient visit, est	CH	B					
99215	Office/outpatient visit, est	CH	B					
99241	Office consultation	CH	B					
99242	Office consultation	CH	B					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99243	Office consultation	CH	B					
99244	Office consultation	CH	B					
99245	Office consultation	CH	B					
99281	Emergency dept visit	CH	B					
99282	Emergency dept visit	CH	B					
99283	Emergency dept visit	CH	B					
99284	Emergency dept visit	CH	B					
99285	Emergency dept visit	CH	B					
99289	Ped crit care transport		N					
99290	Ped crit care transport addl		N					
99291	Critical care, first hour	CH	B					
99292	Critical care, add'l 30 min	CH	B					
99300	Ic, infant pbw 2501-5000 gm		N					
99354	Prolonged service, office		N					
99355	Prolonged service, office		N					
99358	Prolonged serv, w/o contact		N					
99359	Prolonged serv, w/o contact		N					
99361	Physician/team conference		N					
99362	Physician/team conference		N					
99431	Initial care, normal newborn	CH	V	0605	1.0057	61.90		12.38
99432	Newborn care, not in hosp		N					
99436	Attendance, birth		N					
99440	Newborn resuscitation		S	0094	2.4630	151.60	46.29	30.32
0003T	Cervicography	CH	T	0191	0.1501	9.24		1.85
0008T	Upper gi endoscopy w/suture		T	0422	27.5493	1,695.69	448.81	339.14
0016T	Thermotx choroid vasc lesion		T	0235	4.0750	250.82	61.14	50.16
0017T	Photocoagulat macular drusen		T	0235	4.0750	250.82	61.14	50.16
0018T	Transcranial magnetic stimul		S	0215	0.5760	35.45		7.09
0027T	Endoscopic epidural lysis		T	0220	17.7609	1,093.20		218.64
0028T	Dexa body composition study		N					
0031T	Speculoscopy		N					
0032T	Speculoscopy w/direct sample		N					
0042T	Ct perfusion w/contrast, cbf		N					
0044T	Whole body photography		N					
0045T	Whole body photography		N					
0046T	Cath lavage, mammary duct(s		T	0021	14.9563	920.58	219.48	184.12
0047T	Cath lavage, mammary duct(s)		T	0021	14.9563	920.58	219.48	184.12
0054T	Bone surgery using computer		S	0302	5.5005	338.56	105.94	67.71
0055T	Bone surgery using computer		S	0302	5.5005	338.56	105.94	67.71
0056T	Bone surgery using computer		S	0302	5.5005	338.56	105.94	67.71
0058T	Cryopreservation, ovary tiss		X	0348	0.8928	54.95		10.99
0059T	Cryopreservation, oocyte		X	0348	0.8928	54.95		10.99
0062T	Rep intradisc annulus;1 lev		T	0050	25.0600	1,542.47		308.49
0063T	Rep intradisc annulus;>1lev		T	0050	25.0600	1,542.47		308.49
0064T	Spectroscop eval expired gas		X	0367	0.6253	38.49	14.64	7.70
0067T	Ct colonography;dx		S	0333	5.0020	307.88	121.52	61.58
0069T	Analysis only heart sound		N					
0070T	Interp only heart sound		N					
0071T	U/s leiomyomata ablate <200		T	0195	28.7410	1,769.04	483.80	353.81
0072T	U/s leiomyomata ablate >200		T	0202	42.8756	2,639.04	981.50	527.81
0073T	Delivery, comp imrt		S	0412	5.5021	338.66		67.73
0083T	Stereotactic rad tx mngmt		N					
0084T	Temp prostate urethral stent		T	0164	2.1159	130.24		26.05
0085T	Breath test heart reject		X	0340	0.6211	38.23		7.65
0086T	L ventricle fill pressure		N					
0087T	Sperm eval hyaluronan		X	0348	0.8928	54.95		10.99
0088T	Rf tongue base vol reduxn		T	0253	16.4494	1,012.48	282.29	202.50
0089T	Actigraphy testing, 3-day		S	0218	1.1993	73.82		14.76
0099T	Implant corneal ring		T	0233	14.9969	923.07	266.33	184.61
0100T	Prosth retina receive&gen		T	0672	36.8820	2,270.12		454.02
0101T	Extracorp shockwv tx,hi enrg	CH	T	0050	25.0600	1,542.47		308.49
0102T	Extracorp shockwv tx,anesth	CH	T	0050	25.0600	1,542.47		308.49
0106T	Touch quant sensory test		X	0341	0.0914	5.63	2.25	1.13
0107T	Vibrate quant sensory test		X	0341	0.0914	5.63	2.25	1.13
0108T	Cool quant sensory test		X	0341	0.0914	5.63	2.25	1.13
0109T	Heat quant sensory test		X	0341	0.0914	5.63	2.25	1.13
0110T	Nos quant sensory test		X	0341	0.0914	5.63	2.25	1.13
0120T	Fibroadenoma cryoablate, ea		T	0029	28.1505	1,732.69		346.54
0123T	Scleral fistulization		T	0234	22.9479	1,412.47	511.31	282.49
0124T	Conjunctival drug placement		T	0232	5.9800	368.07	92.21	73.61

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0126T	Chd risk imt study		N					
0133T	Esophageal implant injexn	CH	T	0422	27.5493	1,695.69	448.81	339.14
0135T	Perq cryoablate renal tumor	CH	T	0423	39.0235	2,401.94		480.39
0137T	Prostate saturation sampling		T	0184	5.9892	368.64	96.27	73.73
0144T	CT heart wo dye; qual calc		S	0398	4.2511	261.66	100.06	52.33
0145T	CT heart w/wo dye funct		S	0376	4.9770	306.34	119.77	61.27
0146T	CCTA w/wo dye		S	0376	4.9770	306.34	119.77	61.27
0147T	CCTA w/wo, quan calcium		S	0376	4.9770	306.34	119.77	61.27
0148T	CCTA w/wo, strxr		S	0377	6.7443	415.12	158.84	83.02
0149T	CCTA w/wo, strxr quan calc		S	0377	6.7443	415.12	158.84	83.02
0150T	CCTA w/wo, disease strxr		S	0398	4.2511	261.66	100.06	52.33
0151T	CT heart funct add-on		S	0282	1.5552	95.72	37.92	19.14
0152T	Computer chest add-on		N					
0154T	Implant aneur sensor study		X	0097	1.0245	63.06	23.79	12.61
A0800	Amb trans 7pm-7am	CH	E					
A4218	Sterile saline or water		N					
A4220	Infusion pump refill kit		N					
A4248	Chlorhexidine antisept		N					
A4262	Temporary tear duct plug		N					
A4263	Permanent tear duct plug		N					
A4270	Disposable endoscope sheath		N					
A4300	Cath impl vasc access portal		N					
A4301	Implantable access syst perc		N					
A4561	Pessary rubber, any type		N					
A4562	Pessary, non rubber,any type		N					
A4641	Radiopharm dx agent noc		N					
A4642	In111 satumomab	CH	K	0704		192.12		38.42
A9500	Tc99m sestamibi	CH	K	1600		82.58		16.52
A9502	Tc99m tetrofosmin	CH	K	0705		73.81		14.76
A9503	Tc99m medronate		N					
A9504	Tc99m apcitide	CH	N					
A9505	TL201 thallium	CH	K	1603		27.18		5.44
A9507	In111 capromab	CH	K	1604		928.19		185.64
A9508	I131 iodobenguate, dx	CH	K	1045		429.55		85.91
A9510	Tc99m disofenin	CH	N					
A9512	Tc99m pertechnetate		N					
A9516	I123 iodide cap, dx	CH	K	9148		27.44		5.49
A9517	I131 iodide cap, rx	CH	K	1064		14.54		2.91
A9521	Tc99m exametazime	CH	K	1096		317.07		63.41
A9524	I131 serum albumin, dx	CH	K	9100		36.78		7.36
A9526	Nitrogen N-13 ammonia	CH	K	0737		230.77		46.15
A9528	Iodine I-131 iodide cap, dx	CH	K	1088		24.86		4.97
A9529	I131 iodide sol, dx	CH	N					
A9530	I131 iodide sol, rx	CH	K	1150		12.60		2.52
A9531	I131 max 100uCi	CH	N					
A9532	I125 serum albumin, dx	CH	N					
A9535	Injection, methylene blue	CH	N					
A9536	Tc99m depreotide	CH	K	0739		67.91		13.58
A9537	Tc99m mebrofenin		N					
A9538	Tc99m pyrophosphate		N					
A9539	Tc99m pentetate	CH	K	0722		56.77		11.35
A9540	Tc99m MAA		N					
A9541	Tc99m sulfur colloid		N					
A9542	In111 ibritumomab, dx	CH	K	1642		1,344.34		268.87
A9543	Y90 ibritumomab, rx	CH	K	1643		12,130.20		2,426.04
A9544	I131 tositumomab, dx	CH	K	1644		1,368.17		273.63
A9545	I131 tositumomab, rx	CH	K	1645		11,868.78		2,373.76
A9546	Co57/58	CH	K	0723		149.44		29.89
A9547	In111 oxyquinoline	CH	K	1646		306.51		61.30
A9548	In111 pentetate	CH	K	1647		262.81		52.56
A9549	Tc99m arcitumomab	CH	K	1648		255.95		51.19
A9550	Tc99m gluceptate	CH	K	0740		236.53		47.31
A9551	Tc99m succimer	CH	K	1650		84.79		16.96
A9552	F18 fdg	CH	K	1651		235.56		47.11
A9553	Cr51 chromate	CH	K	0741		167.62		33.52
A9554	I125 iothalamate, dx	CH	N					
A9555	Rb82 rubidium	CH	K	1654		239.83		47.97
A9556	Ga67 gallium	CH	K	1671		22.73		4.55
A9557	Tc99m bicisate	CH	K	1672		254.46		50.89
A9558	Xe133 xenon 10mci		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A9559	Co57 cyano	CH	K	0724		63.74		12.75
A9560	Tc99m labeled rbc	CH	K	0742		132.95		26.59
A9561	Tc99m oxidronate		N					
A9562	Tc99m mertiatide	CH	K	0743		180.08		36.02
A9563	P32 Na phosphate	CH	K	1675		117.11		23.42
A9564	P32 chromic phosphate	CH	K	1676		222.35		44.47
A9565	In111 pentetreotide	CH	K	1677		185.60		37.12
A9566	Tc99m fanolesomab	CH	K	1678		527.31		105.46
A9567	Technetium TC-99m aerosol	CH	N					
A9600	Sr89 strontium	CH	K	0701		533.58		106.72
A9605	Sm 153 lexidronm	CH	K	0702		1,316.41		263.28
A9698	Non-rad contrast materialNOC		N					
A9699	Radiopharm rx agent noc		N					
C1178	BUSULFAN IV, 6 Mg		K	1178		24.87		4.97
C1300	HYPERBARIC Oxygen		S	0659	1.5925	98.02		19.60
C1713	Anchor/screw bn/bn,tis/bn		N					
C1714	Cath, trans atherectomy, dir		N					
C1715	Brachytherapy needle		N					
C1716	Brachytx source, Gold 198	CH	K	1716	0.4493	27.65		5.53
C1717	Brachytx source, HDR Ir-192	CH	K	1717	2.1922	134.93		26.99
C1718	Brachytx source, Iodine 125	CH	K	1718	0.5754	35.42		7.08
C1719	Brachytx sour,Non-HDR Ir-192	CH	K	1719	0.5108	31.44		6.29
C1720	Brachytx sour, Palladium 103	CH	K	1720	0.7945	48.90		9.78
C1721	AICD, dual chamber		N					
C1722	AICD, single chamber		N					
C1724	Cath, trans atherec,rotation		N					
C1725	Cath, translumin non-laser		N					
C1726	Cath, bal dil, non-vascular		N					
C1727	Cath, bal tis dis, non-vas		N					
C1728	Cath, brachytx seed adm		N					
C1729	Cath, drainage		N					
C1730	Cath, EP, 19 or few elect		N					
C1731	Cath, EP, 20 or more elec		N					
C1732	Cath, EP, diag/abl, 3D/vect		N					
C1733	Cath, EP, othr than cool-tip		N					
C1750	Cath, hemodialysis,long-term		N					
C1751	Cath, inf, per/cent/midline		N					
C1752	Cath,hemodialysis,short-term		N					
C1753	Cath, intravas ultrasound		N					
C1754	Catheter, intradiscal		N					
C1755	Catheter, intraspinal		N					
C1756	Cath, pacing, transesoph		N					
C1757	Cath, thrombectomy/embolect		N					
C1758	Catheter, ureteral		N					
C1759	Cath, intra echocardiography		N					
C1760	Closure dev, vasc		N					
C1762	Conn tiss, human(inc fascia)		N					
C1763	Conn tiss, non-human		N					
C1764	Event recorder, cardiac		N					
C1765	Adhesion barrier		N					
C1766	Intro/sheath,strble,non-peel		N					
C1767	Generator, neuro non-recharg		N					
C1768	Graft, vascular		N					
C1769	Guide wire		N					
C1770	Imaging coil, MR, insertable		N					
C1771	Rep dev, urinary, w/sling		N					
C1772	Infusion pump, programmable		N					
C1773	Ret dev, insertable		N					
C1776	Joint device (implantable)		N					
C1777	Lead, AICD, endo single coil		N					
C1778	Lead, neurostimulator		N					
C1779	Lead, pmkr, transvenous VDD		N					
C1780	Lens, intraocular (new tech)		N					
C1781	Mesh (implantable)		N					
C1782	Morcellator		N					
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					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1788	Port, indwelling, imp		N					
C1789	Prosthesis, breast, imp		N					
C1813	Prosthesis, penile, inflatab		N					
C1814	Retinal tamp, silicone oil		N					
C1815	Pros, urinary sph, imp		N					
C1816	Receiver/transmitter, neuro		N					
C1817	Septal defect imp sys		N					
C1818	Integrated keratoprosthesis		N					
C1819	Tissue localization-excision		N					
C1820	Generator neuro rechg bat sy		H	1820				
C1874	Stent, coated/cov w/del sys		N					
C1875	Stent, coated/cov w/o del sy		N					
C1876	Stent, non-coa/non-cov w/del		N					
C1877	Stent, non-coat/cov w/o del		N					
C1878	Matrl for vocal cord		N					
C1879	Tissue marker, implantable		N					
C1880	Vena cava filter		N					
C1881	Dialysis access system		N					
C1882	AICD, other than sing/dual		N					
C1883	Adapt/ext, pacing/neuro lead		N					
C1884	Embolization Protect syst		N					
C1885	Cath, translumin angio laser		N					
C1887	Catheter, guiding		N					
C1888	Endovas non-cardiac abl cath		N					
C1891	Infusion pump,non-prog, perm		N					
C1892	Intro/sheath,fixed,peel-away		N					
C1893	Intro/sheath, fixed,non-peel		N					
C1894	Intro/sheath, non-laser		N					
C1895	Lead, AICD, endo dual coil		N					
C1896	Lead, AICD, non sing/dual		N					
C1897	Lead, neurostim test kit		N					
C1898	Lead, pmkr, other than trans		N					
C1899	Lead, pmkr/AICD combination		N					
C1900	Lead, coronary venous		N					
C2614	Probe, perc lumb disc		N					
C2615	Sealant, pulmonary, liquid		N					
C2616	Brachytx source, Yttrium-90	CH	K	2616	272.7710	16,789.33		3,357.87
C2617	Stent, non-cor, tem w/o del		N					
C2618	Probe, cryoablation		N					
C2619	Pmkr, dual, non rate-resp		N					
C2620	Pmkr, single, non rate-resp		N					
C2621	Pmkr, other than sing/dual		N					
C2622	Prosthesis, penile, non-inf		N					
C2625	Stent, non-cor, tem w/del sy		N					
C2626	Infusion pump, non-prog,temp		N					
C2627	Cath, suprapubic/cystoscopic		N					
C2628	Catheter, occlusion		N					
C2629	Intro/sheath, laser		N					
C2630	Cath, EP, cool-tip		N					
C2631	Rep dev, urinary, w/o sling		N					
C2632	Brachytx sol, I-125, per mCi	CH	K	2632	0.3139	19.32		3.86
C2633	Brachytx source, Cesium-131	CH	K	2633	1.4622	90.00		18.00
C2634	Brachytx source, HA, I-125	CH	K	2634	0.4172	25.68		5.14
C2635	Brachytx source, HA, P-103	CH	K	2635	0.8820	54.29		10.86
C2636	Brachytx linear source,P-103	CH	K	2636	0.6360	39.15		7.83
C2637	Brachytx, Ytterbium-169	CH	K	2637	0.4172	25.68		5.14
C8900	MRA w/cont, abd		S	0284	6.2589	385.24	148.40	77.05
C8901	MRA w/o cont, abd		S	0336	5.8500	360.07	139.68	72.01
C8902	MRA w/o fol w/cont, abd		S	0337	8.3423	513.48	202.50	102.70
C8903	MRI w/cont, breast, uni		S	0284	6.2589	385.24	148.40	77.05
C8904	MRI w/o cont, breast, uni		S	0336	5.8500	360.07	139.68	72.01
C8905	MRI w/o fol w/cont, brst, un		S	0337	8.3423	513.48	202.50	102.70
C8906	MRI w/cont, breast, bi		S	0284	6.2589	385.24	148.40	77.05
C8907	MRI w/o cont, breast, bi		S	0336	5.8500	360.07	139.68	72.01
C8908	MRI w/o fol w/cont, breast,		S	0337	8.3423	513.48	202.50	102.70
C8909	MRA w/cont, chest		S	0284	6.2589	385.24	148.40	77.05
C8910	MRA w/o cont, chest		S	0336	5.8500	360.07	139.68	72.01
C8911	MRA w/o fol w/cont, chest		S	0337	8.3423	513.48	202.50	102.70
C8912	MRA w/cont, lwr ext		S	0284	6.2589	385.24	148.40	77.05
C8913	MRA w/o cont, lwr ext		S	0336	5.8500	360.07	139.68	72.01

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C8914	MRA w/o fol w/cont, lwr ext		S	0337	8.3423	513.48	202.50	102.70
C8918	MRA w/cont, pelvis		S	0284	6.2589	385.24	148.40	77.05
C8919	MRA w/o cont, pelvis		S	0336	5.8500	360.07	139.68	72.01
C8920	MRA w/o fol w/cont, pelvis		S	0337	8.3423	513.48	202.50	102.70
C8950	IV inf, tx/dx, up to 1 hr	CH	S	0440	1.8285	112.55		22.51
C8951	IV inf, tx/dx, each addl hr	CH	S	0437	0.4107	25.28		5.06
C8952	Tx, prophy, dx IV push	CH	S	0438	0.7892	48.58		9.72
C8953	Chemotx adm, IV push	CH	S	0439	1.5841	97.50		19.50
C8954	Chemotx adm, IV inf up to 1h	CH	S	0441	2.5071	154.31		30.86
C8955	Chemotx adm, IV inf, addl hr	CH	S	0438	0.7892	48.58		9.72
C8957	Prolonged IV inf, req pump	CH	S	0441	2.5071	154.31		30.86
C9003	Palivizumab, per 50 mg		K	9003		609.62		121.92
C9113	Inj pantoprazole sodium, via		N					
C9121	Injection, argatroban		K	9121		16.40		3.28
C9220	Sodium hyaluronate	CH	K	9220		197.62		39.52
C9221	Graftjacket Reg Matrix	CH	B					
C9222	Graftjacket SftTis	CH	K	9222		883.78		176.76
C9224	Injection, galsulfase		K	9224		1,503.23		300.65
C9225	Fluocinolone acetonide		G	9225		19,345.00		3,869.00
C9227	Injection, micafungin sodium		G	9227		1.98		0.40
C9228	Injection, tigecycline		G	9228		0.96		0.19
C9716	Radiofrequency energy to anu	CH	T	0150	29.4386	1,811.98	437.12	362.40
C9723	Dyn IR Perf Img		S	1502		75.00		15.00
C9724	EPS gast cardia plic		T	0422	27.5493	1,695.69	448.81	339.14
C9725	Place endorectal app		S	1507		550.00		110.00
C9726	Rxt breast appl place/remov		S	1508		650.00		130.00
D0150	Comprehensve oral evaluation		S	0330	9.5891	590.22		118.04
D0240	Intraoral occlusal film		S	0330	9.5891	590.22		118.04
D0250	Extraoral first film		S	0330	9.5891	590.22		118.04
D0260	Extraoral ea additional film		S	0330	9.5891	590.22		118.04
D0270	Dental bitewing single film		S	0330	9.5891	590.22		118.04
D0272	Dental bitewings two films		S	0330	9.5891	590.22		118.04
D0274	Dental bitewings four films		S	0330	9.5891	590.22		118.04
D0277	Vert bitewings-sev to eight		S	0330	9.5891	590.22		118.04
D0460	Pulp vitality test		S	0330	9.5891	590.22		118.04
D1510	Space maintainer fxd unilat		S	0330	9.5891	590.22		118.04
D1515	Fixed bilat space maintainer		S	0330	9.5891	590.22		118.04
D1520	Remove unilat space maintain		S	0330	9.5891	590.22		118.04
D1525	Remove bilat space maintain		S	0330	9.5891	590.22		118.04
D1550	Recement space maintainer		S	0330	9.5891	590.22		118.04
D2999	Dental unspec restorative pr		S	0330	9.5891	590.22		118.04
D3460	Endodontic endosseous implan		S	0330	9.5891	590.22		118.04
D3999	Endodontic procedure		S	0330	9.5891	590.22		118.04
D4260	Osseous surgery per quadrant		S	0330	9.5891	590.22		118.04
D4263	Bone replce graft first site		S	0330	9.5891	590.22		118.04
D4264	Bone replce graft each add		S	0330	9.5891	590.22		118.04
D4268	Surgical revision procedure		S	0330	9.5891	590.22		118.04
D4270	Pedicle soft tissue graft pr		S	0330	9.5891	590.22		118.04
D4271	Free soft tissue graft proc		S	0330	9.5891	590.22		118.04
D4273	Subepithelial tissue graft		S	0330	9.5891	590.22		118.04
D4355	Full mouth debridement		S	0330	9.5891	590.22		118.04
D4381	Localized delivery antimicro		S	0330	9.5891	590.22		118.04
D5911	Facial moulage sectional		S	0330	9.5891	590.22		118.04
D5912	Facial moulage complete		S	0330	9.5891	590.22		118.04
D5983	Radiation applicator		S	0330	9.5891	590.22		118.04
D5984	Radiation shield		S	0330	9.5891	590.22		118.04
D5985	Radiation cone locator		S	0330	9.5891	590.22		118.04
D5987	Commissure splint		S	0330	9.5891	590.22		118.04
D6920	Dental connector bar		S	0330	9.5891	590.22		118.04
D7111	Extraction coronal remnants		S	0330	9.5891	590.22		118.04
D7140	Extraction erupted tooth/exr		S	0330	9.5891	590.22		118.04
D7210	Rem imp tooth w mucoper flp		S	0330	9.5891	590.22		118.04
D7220	Impact tooth remov soft tiss		S	0330	9.5891	590.22		118.04
D7230	Impact tooth remov part bony		S	0330	9.5891	590.22		118.04
D7240	Impact tooth remov comp bony		S	0330	9.5891	590.22		118.04
D7241	Impact tooth rem bony w/comp		S	0330	9.5891	590.22		118.04
D7250	Tooth root removal		S	0330	9.5891	590.22		118.04
D7260	Oral antral fistula closure		S	0330	9.5891	590.22		118.04
D7261	Primary closure sinus perf		S	0330	9.5891	590.22		118.04
D7291	Transseptal fiberotomy		S	0330	9.5891	590.22		118.04

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D7940	Reshaping bone orthognathic		S	0330	9.5891	590.22		118.04
D9110	Tx dental pain minor proc		N					
D9230	Analgesia		N					
D9248	Sedation (non-iv)		N					
D9630	Other drugs/medicaments		S	0330	9.5891	590.22		118.04
D9930	Treatment of complications		S	0330	9.5891	590.22		118.04
D9940	Dental occlusal guard		S	0330	9.5891	590.22		118.04
D9950	Occlusion analysis		S	0330	9.5891	590.22		118.04
D9951	Limited occlusal adjustment		S	0330	9.5891	590.22		118.04
D9952	Complete occlusal adjustment		S	0330	9.5891	590.22		118.04
E0616	Cardiac event recorder		N					
E0749	Elec osteogen stim implanted		N					
E0782	Non-programble infusion pump		N					
E0783	Programmable infusion pump		N					
E0785	Replacement impl pump cathet		N					
E0786	Implantable pump replacement		N					
E0830	Ambulatory traction device		N					
E1399	Durable medical equipment mi		N					
G0008	Admin influenza virus vac	CH	S	0350	0.4107	25.28	0.00	0.00
G0009	Admin pneumococcal vaccine	CH	S	0350	0.4107	25.28	0.00	0.00
G0101	CA screen;pelvic/breast exam	CH	V	0604	0.8083	49.75		9.95
G0102	Prostate ca screening; dre		N					
G0104	CA screen;flexi sigmoidscope		S	0159	3.8973	239.88		59.97
G0105	Colorectal scrn; hi risk ind		T	0158	7.8134	480.92		120.23
G0106	Colon CA screen;barium enema		S	0157	2.4974	153.72		30.74
G0117	Glaucoma scrn hgh risk direc		S	0230	0.8126	50.02	14.97	10.00
G0118	Glaucoma scrn hgh risk direc		S	0230	0.8126	50.02	14.97	10.00
G0120	Colon ca scrn; barium enema		S	0157	2.4974	153.72		30.74
G0121	Colon ca scrn not hi rsk ind		T	0158	7.8134	480.92		120.23
G0127	Trim nail(s)		T	0009	0.6803	41.87		8.37
G0129	Partial hosp prog service		P	0033	3.3837	208.27		41.65
G0130	Single energy x-ray study		X	0260	0.7276	44.78		8.96
G0166	Extrnl counterpulse, per tx		T	0678	1.7263	106.26		21.25
G0173	Linear acc stereo radsur com	CH	S	0067	65.7255	4,045.47		809.09
G0175	OPPS Service,sched team conf	CH	V	0608	2.1226	130.65		26.13
G0176	OPPS/PHP;activity therapy		P	0033	3.3837	208.27		41.65
G0177	OPPS/PHP; train&educ serv		P	0033	3.3837	208.27		41.65
G0186	Dstry eye lesn,fdr vssl tech		T	0235	4.0750	250.82	61.14	50.16
G0237	Therapeutic procd strg endur		S	0411	0.3793	23.35		4.67
G0238	Oth resp proc, indiv		S	0411	0.3793	23.35		4.67
G0239	Oth resp proc, group		S	0411	0.3793	23.35		4.67
G0243	Multisour photon stero treat		S	0127	126.8566	7,808.15		1,561.63
G0245	Initial foot exam pt lops	CH	V	0604	0.8083	49.75		9.95
G0246	Followup eval of foot pt lop	CH	V	0605	1.0057	61.90		12.38
G0247	Routine footcare pt w lops		T	0009	0.6803	41.87		8.37
G0248	Demonstrate use home inr mon	CH	V	0604	0.8083	49.75		9.95
G0249	Provide test material,equipm	CH	V	0604	0.8083	49.75		9.95
G0251	Linear acc based stero radio	CH	S	0065	22.4428	1,381.38		276.28
G0257	Unsched dialysis ESRD pt hos		S	0170	6.8096	419.14		83.83
G0259	Inject for sacroiliac joint		N					
G0260	Inj for sacroiliac jt anesth		T	0206	5.5439	341.23	75.55	68.25
G0267	Bone marrow or psc harvest		S	0110	3.4570	212.78		42.56
G0268	Removal of impacted wax md		X	0340	0.6211	38.23		7.65
G0269	Occlusive device in vein art		N					
G0275	Renal angio, cardiac cath		N					
G0278	Iliac art angio,cardiac cath		N					
G0288	Recon, CTA for surg plan		S	0417	3.1140	191.67		38.33
G0289	Arthro, loose body + chondro		N					
G0290	Drug-eluting stents, single		T	0656	106.8902	6,579.20		1,315.84
G0291	Drug-eluting stents,each add		T	0656	106.8902	6,579.20		1,315.84
G0293	Non-cov surg proc,clin trial	CH	X	0340	0.6211	38.23		7.65
G0294	Non-cov proc, clinical trial	CH	X	0340	0.6211	38.23		7.65
G0297	Insert single chamber/cd		T	0107	279.2049	17,185.34		3,437.07
G0298	Insert dual chamber/cd		T	0107	279.2049	17,185.34		3,437.07
G0299	Inser/repos single icd+leads		T	0108	370.5535	22,807.94		4,561.59
G0300	Insert reposit lead dual+gen		T	0108	370.5535	22,807.94		4,561.59
G0302	Pre-op service LVRS complete		S	1509		750.00		150.00
G0303	Pre-op service LVRS 10–15dos		S	1507		550.00		110.00
G0304	Pre-op service LVRS 1–9 dos		S	1504		250.00		50.00
G0305	Post op service LVRS min 6		S	1504		250.00		50.00

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0332	Preadmin IV immunoglobulin	CH	B					
G0339	Robot lin-radsurg com, first	CH	S	0067	65.7255	4,045.47		809.09
G0340	Robt lin-radsurg fractx 2–5	CH	S	0066	47.2213	2,906.52		581.30
G0344	Initial preventive exam	CH	V	0605	1.0057	61.90		12.38
G0364	Bone marrow aspirate &biopsy	CH	T	0002	1.0948	67.39		13.48
G0365	Vessel mapping hemo access		S	0267	2.5166	154.90	60.80	30.98
G0367	EKG tracing for initial prev		S	0099	0.3835	23.60		4.72
G0375	Smoke/tobacco counselng 3–10	CH	X	0031	0.1716	10.56		2.11
G0376	Smoke/tobacco counseling >10	CH	X	0031	0.1716	10.56		2.11
G0378	Hospital observation per hr		Q	0339	7.1587	440.63		88.13
G0379	Direct admit hospital observ	CH	Q	0604	0.8083	49.75		9.95
G3001	Admin + supply, tositumomab	CH	S	0442	24.5410	1,510.52		302.10
J0120	Tetracyclin injection		N					
J0128	Abarelix injection	CH	K	9216		66.20		13.24
J0130	Abciximab injection		K	1605		452.96		90.59
J0132	Acetylcysteine injection		K	1680		1.86		0.37
J0133	Acyclovir injection		N					
J0135	Adalimumab injection		K	1083		304.40		60.88
J0150	Injection adenosine 6 MG		K	0379		29.90		5.98
J0152	Adenosine injection		K	0917		69.41		13.88
J0170	Adrenalin epinephrin inject		N					
J0180	Agalsidase beta injection		K	9208		126.00		25.20
J0190	Inj biperiden lactate/5 mg	CH	K	3038		88.36		17.67
J0200	Alatrofloxacin mesylate		N					
J0205	Alglucerase injection		K	0900		38.85		7.77
J0207	Amifostine		K	7000		448.41		89.68
J0210	Methyldopate hcl injection		K	2210		9.86		1.97
J0215	Alefacept		K	1633		26.03		5.21
J0256	Alpha 1 proteinase inhibitor		K	0901		3.21		0.64
J0278	Amikacin sulfate injection	CH	N					
J0280	Aminophyllin 250 MG inj		N					
J0282	Amiodarone HCl		N					
J0285	Amphotericin B	CH	N					
J0287	Amphotericin b lipid complex		K	9024		11.10		2.22
J0288	Ampho b cholesteryl sulfate		K	0735		12.00		2.40
J0289	Amphotericin b liposome inj		K	0736		17.40		3.48
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					
J0350	Injection anistreplase 30 u		K	1606		2,265.46		453.09
J0360	Hydralazine hcl injection		N					
J0365	Aprotonin, 10,000 kiu		K	1682		2.32		0.46
J0380	Inj metaraminol bitartrate	CH	K	3039		17.68		3.54
J0390	Chloroquine injection		N					
J0395	Arbutamine HCl injection		K	9031		160.00		32.00
J0456	Azithromycin		N					
J0460	Atropine sulfate injection		N					
J0470	Dimecaprol injection	CH	N					
J0475	Baclofen 10 MG injection		K	9032		191.50		38.30
J0476	Baclofen intrathecal trial		K	1631		70.20		14.04
J0480	Basiliximab		K	1683		1,388.81		277.76
J0500	Dicyclomine injection		N					
J0515	Inj benztropine mesylate		N					
J0520	Bethanechol chloride inject		N					
J0530	Penicillin g benzathine inj		N					
J0540	Penicillin g benzathine inj		N					
J0550	Penicillin g benzathine inj		N					
J0560	Penicillin g benzathine inj		N					
J0570	Penicillin g benzathine inj		N					
J0580	Penicillin g benzathine inj	CH	K	3040		67.86		13.57
J0583	Bivalirudin	CH	K	3041		1.62		0.32
J0585	Botulinum toxin a per unit		K	0902		4.85		0.97
J0587	Botulinum toxin type B		K	9018		7.85		1.57
J0592	Buprenorphine hydrochloride		N					
J0595	Butorphanol tartrate 1 mg		N					
J0600	Edetate calcium disodium inj		K	0892		39.80		7.96
J0610	Calcium gluconate injection		N					
J0620	Calcium glycer&lact/10 ML		N					
J0630	Calcitonin salmon injection	CH	N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0636	Inj calcitriol per 0.1 mcg		N					
J0637	Caspofungin acetate		K	9019		32.19		6.44
J0640	Leucovorin calcium injection		N					
J0670	Inj mepivacaine HCL/10 ml		N					
J0690	Cefazolin sodium injection		N					
J0692	Cefepime HCl for injection		N					
J0694	Cefoxitin sodium injection		N					
J0696	Ceftriaxone sodium injection		N					
J0697	Sterile cefuroxime injection		N					
J0698	Cefotaxime sodium injection		N					
J0702	Betamethasone acet&sod phosp		N					
J0704	Betamethasone sod phosp/4 MG		N					
J0706	Caffeine citrate injection		K	0876		3.34		0.67
J0710	Cephapirin sodium injection		N					
J0713	Inj ceftazidime per 500 mg		N					
J0715	Ceftizoxime sodium/500 MG		N					
J0720	Chloramphenicol sodium injec		N					
J0725	Chorionic gonadotropin/1000u		N					
J0735	Clonidine hydrochloride		K	0935		62.71		12.54
J0740	Cidofovir injection		K	9033		757.03		151.41
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		4.22		0.84
J0800	Corticotropin injection		K	1280		108.85		21.77
J0835	Inj cosyntropin per 0.25 MG		K	0835		63.55		12.71
J0850	Cytomegalovirus imm IV/vial		K	0903		755.79		151.16
J0878	Daptomycin injection	CH	K	9124		0.31		0.06
J0881	Darbepoetin alfa, non-esrd		K	1685		3.00		0.60
J0882	Darbepoetin alfa, esrd use	CH	A					
J0885	Epoetin alfa, non-esrd		K	1686		9.25		1.85
J0886	Epoetin alfa, esrd	CH	A					
J0895	Deferoxamine mesylate inj		K	0895		14.77		2.95
J0900	Testosterone enanthate inj		N					
J0945	Brompheniramine maleate inj		N					
J0970	Estradiol valerate injection		N					
J1000	Depo-estradiol cypionate inj		N					
J1020	Methylprednisolone 20 MG inj		N					
J1030	Methylprednisolone 40 MG inj		N					
J1040	Methylprednisolone 80 MG inj		N					
J1051	Medroxyprogesterone inj		N					
J1060	Testosterone cypionate 1 ML		N					
J1070	Testosterone cypionat 100 MG		N					
J1080	Testosterone cypionat 200 MG		N					
J1094	Inj dexamethasone acetate		N					
J1100	Dexamethasone sodium phos		N					
J1110	Inj dihydroergotamine mesylt	CH	N					
J1120	Acetazolamid sodium injectio		N					
J1160	Digoxin injection		N					
J1162	Digoxin immune fab (ovine)		K	1687		527.46		105.49
J1165	Phenytoin sodium injection		N					
J1170	Hydromorphone injection		N					
J1180	Dyphylline injection	CH	N					
J1190	Dexrazoxane HCl injection		K	0726		179.62		35.92
J1200	Diphenhydramine hcl injectio		N					
J1205	Chlorothiazide sodium inj		N					
J1212	Dimethyl sulfoxide 50% 50 ML		N					
J1230	Methadone injection		N					
J1240	Dimenhydrinate injection		N					
J1245	Dipyridamole injection		N					
J1250	Inj dobutamine HCL/250 mg		N					
J1260	Dolasetron mesylate		K	0750		6.76		1.35
J1265	Dopamine injection		N					
J1270	Injection, doxercalciferol		N					
J1320	Amitriptyline injection		N					
J1325	Epoprostenol injection		N					
J1327	Eptifibatide injection		K	1607		13.31		2.66

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1330	Ergonovine maleate injection		K	1330		27.56		5.51
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		57.78		11.56
J1430	Ethanolamine oleate 100 mg		K	1688		71.57		14.31
J1435	Injection estrone per 1 MG		N					
J1436	Etidronate disodium inj		K	1436		70.73		14.15
J1438	Etanercept injection		K	1608		154.12		30.82
J1440	Filgrastim 300 mcg injection		K	0728		182.53		36.51
J1441	Filgrastim 480 mcg injection		K	7049		289.59		57.92
J1450	Fluconazole		N					
J1451	Fomepizole, 15 mg		K	1689		11.82		2.36
J1452	Intraocular Fomivirsen na		K	9040		210.00		42.00
J1455	Foscarnet sodium injection	CH	K	3042		10.69		2.14
J1457	Gallium nitrate injection	CH	N					
J1460	Gamma globulin 1 CC inj	CH	K	3043		10.59		2.12
J1565	RSV-ivig		K	0906		16.02		3.20
J1566	Immune globulin, powder		K	2731		22.05		4.41
J1567	Immune globulin, liquid		K	2732		28.82		5.76
J1570	Ganciclovir sodium injection		N					
J1580	Garamycin gentamicin inj		N					
J1590	Gatifloxacin injection		N					
J1595	Injection glatiramer acetate		N					
J1600	Gold sodium thiomaleate inj		N					
J1610	Glucagon hydrochloride/1 MG		K	9042		62.42		12.48
J1620	Gonadorelin hydroch/100 mcg		K	7005		178.59		35.72
J1626	Granisetron HCl injection		K	0764		6.80		1.36
J1630	Haloperidol injection		N					
J1631	Haloperidol decanoate inj		N					
J1640	Hemin, 1 mg		K	1690		6.59		1.32
J1642	Inj heparin sodium per 10 u		N					
J1644	Inj heparin sodium per 1000u		N					
J1645	Dalteparin sodium		N					
J1650	Inj enoxaparin sodium		N					
J1652	Fondaparinux sodium		N					
J1655	Tinzaparin sodium injection		K	1655		2.18		0.44
J1670	Tetanus immune globulin inj		K	1670		90.71		18.14
J1700	Hydrocortisone acetate inj		N					
J1710	Hydrocortisone sodium ph inj		N					
J1720	Hydrocortisone sodium succ i		N					
J1730	Diazoxide injection		K	1740		110.88		22.18
J1742	Ibutilide fumarate injection		K	9044		249.01		49.80
J1745	Infliximab injection		K	7043		53.73		10.75
J1751	Iron dextran 165 injection		K	1691		12.30		2.46
J1752	Iron dextran 267 injection		K	1692		10.17		2.03
J1756	Iron sucrose injection		K	9046		0.36		0.07
J1785	Injection imiglucerase/unit		K	0916		3.87		0.77
J1790	Droperidol injection		N					
J1800	Propranolol injection		N					
J1815	Insulin injection		N					
J1817	Insulin for insulin pump use		N					
J1830	Interferon beta-1b/.25 MG		K	0910		91.34		18.27
J1835	Itraconazole injection		K	9047		36.23		7.25
J1840	Kanamycin sulfate 500 MG inj		N					
J1850	Kanamycin sulfate 75 MG inj		N					
J1885	Ketorolac tromethamine inj		N					
J1890	Cephalothin sodium injection		N					
J1931	Laronidase injection		K	9209		23.64		4.73
J1940	Furosemide injection		N					
J1945	Lepirudin		K	1693		146.38		29.28
J1950	Leuprolide acetate/3.75 MG		K	0800		440.36		88.07
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		23.50		4.70

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2060	Lorazepam injection		N					
J2150	Mannitol injection		N					
J2175	Meperidine hydrochl/100 MG		N					
J2180	Meperidine/promethazine inj		N					
J2185	Meropenem	CH	K	3045		3.76		0.75
J2210	Methylergonovin maleate inj		N					
J2250	Inj midazolam hydrochloride		N					
J2260	Inj milrinone lactate/5 MG		N					
J2270	Morphine sulfate injection		N					
J2271	Morphine so4 injection 100mg		N					
J2275	Morphine sulfate injection		N					
J2278	Ziconotide injection		G	1694		6.20		1.24
J2280	Inj, moxifloxacin 100 mg		N					
J2300	Inj nalbuphine hydrochloride		N					
J2310	Inj naloxone hydrochloride		N					
J2320	Nandrolone decanoate 50 MG		N					
J2321	Nandrolone decanoate 100 MG		N					
J2322	Nandrolone decanoate 200 MG		N					
J2325	Nesiritide injection		K	1695		29.72		5.94
J2353	Octreotide injection, depot		K	1207		89.50		17.90
J2354	Octreotide inj, non-depot	CH	K	3046		4.34		0.87
J2355	Oprelvekin injection		K	7011		243.39		48.68
J2357	Omalizumab injection	CH	K	9300		16.34		3.27
J2360	Orphenadrine injection		N					
J2370	Phenylephrine hcl injection		N					
J2400	Chloroprocaine hcl injection		N					
J2405	Ondansetron hcl injection		K	0768		3.69		0.74
J2410	Oxymorphone hcl injection		N					
J2425	Palifermin injection		K	1696		11.37		2.27
J2430	Pamidronate disodium/30 MG		K	0730		29.31		5.86
J2440	Papaverin hcl injection		N					
J2460	Oxytetracycline injection		N					
J2469	Palonosetron HCl		K	9210		17.51		3.50
J2501	Paricalcitol		N					
J2503	Pegaptanib sodium injection		G	1697		1,107.54		221.51
J2504	Pegademase bovine, 25 iu		K	1739		164.50		32.90
J2505	Injection, pegfilgrastim 6mg		K	9119		2,142.79		428.56
J2510	Penicillin g procaine inj		N					
J2513	Pentastarch 10% solution	CH	N					
J2515	Pentobarbital sodium inj		N					
J2540	Penicillin g potassium inj		N					
J2543	Piperacillin/tazobactam		N					
J2550	Promethazine hcl injection		N					
J2560	Phenobarbital sodium inj		N					
J2590	Oxytocin injection		N					
J2597	Inj desmopressin acetate		N					
J2650	Prednisolone acetate inj		N					
J2670	Totazoline hcl injection		N					
J2675	Inj progesterone per 50 MG		N					
J2680	Fluphenazine decanoate 25 MG		N					
J2690	Procainamide hcl injection		N					
J2700	Oxacillin sodium injeciton	CH	N					
J2710	Neostigmine methylslfte inj		N					
J2720	Inj protamine sulfate/10 MG		N					
J2725	Inj protirelin per 250 mcg		N					
J2730	Pralidoxime chloride inj	CH	N					
J2760	Phentolaine mesylate inj		N					
J2765	Metoclopramide hcl injection		N					
J2770	Quinupristin/dalfopristin		K	2770		108.03		21.61
J2780	Ranitidine hydrochloride inj		N					
J2783	Rasburicase	CH	K	0738		110.36		22.07
J2788	Rho d immune globulin 50 mcg		K	9023		14.13		2.83
J2790	Rho d immune globulin inj		K	0884		97.11		19.42
J2792	Rho(D) immune globulin h, sd		K	1609		13.57		2.71
J2794	Risperidone, long acting	CH	K	9125		4.73		0.95
J2795	Ropivacaine HCl injection		N					
J2800	Methocarbamol injection		N					
J2805	Sincalide injection	CH	N					
J2810	Inj theophylline per 40 MG		N					
J2820	Sargramostim injection		K	0731		23.12		4.62

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2850	Inj secretin synthetic human		K	1700		20.31		4.06
J2910	Aurothioglucose injeciton	CH	N					
J2912	Sodium chloride injection		N					
J2916	Na ferric gluconate complex		N					
J2920	Methylprednisolone injection		N					
J2930	Methylprednisolone injection		N					
J2940	Somatrem injection		K	2940		583.74		116.75
J2941	Somatropin injection		K	7034		43.73		8.75
J2950	Promazine hcl injection		N					
J2993	Reteplase injection		K	9005		754.71		150.94
J2995	Inj streptokinase/250000 IU		K	0911		78.75		15.75
J2997	Alteplase recombinant		K	7048		31.06		6.21
J3000	Streptomycin injection		N					
J3010	Fentanyl citrate injeciton		N					
J3030	Sumatriptan succinate/6 MG		K	3030		51.75		10.35
J3070	Pentazocine injection		N					
J3100	Tenecteplase injection		K	9002		2,059.01		411.80
J3105	Terbutaline sulfate inj		N					
J3120	Testosterone enanthate inj		N					
J3130	Testosterone enanthate inj		N					
J3140	Testosterone suspension inj		N					
J3150	Testosteron propionate inj		N					
J3230	Chlorpromazine hcl injection		N					
J3240	Thyrotropin injection		K	9108		766.61		153.32
J3246	Tirofiban HCl		K	7041		7.61		1.52
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		53.51		10.70
J3301	Triamcinolone acetonide inj		N					
J3302	Triamcinolone diacetate inj		N					
J3303	Triamcinolone hexacetonl inj		N					
J3305	Inj trimetrexate glucoronate		K	7045		144.39		28.88
J3310	Perphenazine injeciton		N					
J3315	Triptorelin pamoate		K	9122		300.90		60.18
J3320	Spectinomycn di-hcl inj		N					
J3350	Urea injection		K	9051		69.10		13.82
J3355	Urofollitropin, 75 iu		K	1741		48.84		9.77
J3360	Diazepam injection		N					
J3364	Urokinase 5000 IU injection		N					
J3365	Urokinase 250,000 IU inj		K	7036		453.41		90.68
J3370	Vancomycin hcl injection		N					
J3396	Verteporfin injection		K	1203		8.89		1.78
J3400	Triflupromazine hcl inj		N					
J3410	Hydroxyzine hcl injection		N					
J3411	Thiamine hcl 100 mg		N					
J3415	Pyridoxine hcl 100 mg		N					
J3420	Vitamin b12 injection		N					
J3430	Vitamin k phytonadione inj		N					
J3465	Injection, voriconazole		K	1052		4.55		0.91
J3470	Hyaluronidase injection	CH	N					
J3471	Ovine, up to 999 USP units	CH	N					
J3472	Ovine, 1000 USP units		K	1703		133.77		26.75
J3475	Inj magnesium sulfate		N					
J3480	Inj potassium chloride		N					
J3485	Zidovudine		N					
J3486	Ziprasidone mesylate		N					
J3487	Zoledronic acid		K	9115		200.82		40.16
J3490	Drugs unclassified injection		N					
J3530	Nasal vaccine inhalation		N					
J3590	Unclassified biologics		N					
J7030	Normal saline solution infus		N					
J7040	Normal saline solution infus		N					
J7042	5% dextrose/normal saline		N					
J7050	Normal saline solution infus		N					
J7060	5% dextrose/water		N					
J7070	D5w infusion		N					
J7100	Dextran 40 infusion		N					
J7110	Dextran 75 infusion		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7120	Ringers lactate infusion		N					
J7130	Hypertonic saline solution		N					
J7188	Inj Vonwillebrand factor iu		K	1704		0.87		0.17
J7189	Factor viia		K	1705		1.08		0.22
J7190	Factor viii		K	0925		0.68		0.14
J7191	Factor VIII (porcine)		K	0926		0.66		0.13
J7192	Factor viii recombinant		K	0927		1.05		0.21
J7193	Factor IX non-recombinant		K	0931		0.88		0.18
J7194	Factor ix complex		K	0928		0.63		0.13
J7195	Factor IX recombinant		K	0932		0.98		0.20
J7197	Antithrombin iii injection		K	0930		1.62		0.32
J7198	Anti-inhibitor		K	0929		1.29		0.26
J7308	Aminolevulinic acid hcl top		K	7308		99.92		19.98
J7310	Ganciclovir long act implant		K	0913		4,200.00		840.00
J7317	Sodium hyaluronate injection		K	7316		112.04		22.41
J7320	Hylan G-F 20 injection		K	1611		196.99		39.40
J7340	Metabolic active D/E tissue		K	1632		27.56		5.51
J7341	Non-human, metabolic tissue		K	1707		1.64		0.33
J7342	Metabolically active tissue		K	9054		15.01		3.00
J7343	Nonmetabolic act d/e tissue		K	1629		15.20		3.04
J7344	Nonmetabolic active tissue		K	9156		66.39		13.28
J7350	Injectable human tissue	CH	N					
J7500	Azathioprine oral 50mg		N					
J7501	Azathioprine parenteral		K	0887		48.73		9.75
J7502	Cyclosporine oral 100 mg		K	0888		3.88		0.78
J7504	Lymphocyte immune globulin		K	0890		295.38		59.08
J7505	Monoclonal antibodies		K	7038		860.94		172.19
J7506	Prednisone oral		N					
J7507	Tacrolimus oral per 1 MG		K	0891		3.40		0.68
J7509	Methylprednisolone oral		N					
J7510	Prednisolone oral per 5 mg		N					
J7511	Antithymocyte globuln rabbit		K	9104		301.48		60.30
J7513	Daclizumab, parenteral		K	1612		345.07		69.01
J7515	Cyclosporine oral 25 mg	CH	N					
J7516	Cyclosporin parenteral 250mg		N					
J7517	Mycophenolate mofetil oral		K	9015		2.50		0.50
J7518	Mycophenolic acid	CH	K	9219		2.15		0.43
J7520	Sirolimus, oral		K	9020		6.84		1.37
J7525	Tacrolimus injection		K	9006		135.17		27.03
J7599	Immunosuppressive drug noc		N					
J7674	Methacholine chloride, neb		N					
J7799	Non-inhalation drug for DME		N					
J8501	Oral aprepitant		G	0868		4.63		0.93
J8510	Oral busulfan		K	7015		1.95		0.39
J8520	Capecitabine, oral, 150 mg		K	7042		3.60		0.72
J8530	Cyclophosphamide oral 25 MG		N					
J8540	Oral dexamethasone	CH	N					
J8560	Etoposide oral 50 MG		K	0802		32.73		6.55
J8597	Antiemetic drug oral NOS		N					
J8600	Melphalan oral 2 MG	CH	K	3047		4.39		0.88
J8610	Methotrexate oral 2.5 MG		N					
J8700	Temozolomide		K	1086		7.16		1.43
J9000	Doxorubic hcl 10 MG vl chemo	CH	K	3048		6.23		1.25
J9001	Doxorubicin hcl liposome inj		K	7046		367.56		73.51
J9010	Alemtuzumab injection		K	9110		525.75		105.15
J9015	Aldesleukin/single use vial		K	0807		734.10		146.82
J9017	Arsenic trioxide		K	9012		32.92		6.58
J9020	Asparaginase injection		K	0814		53.66		10.73
J9025	Azacitidine injection		K	1709		4.09		0.82
J9027	Clofarabine injection		G	1710		116.68		23.34
J9031	Bcg live intravesical vac		K	0809		110.48		22.10
J9035	Bevacizumab injection	CH	K	9214		56.36		11.27
J9040	Bleomycin sulfate injection	CH	N					
J9041	Bortezomib injection		K	9207		29.81		5.96
J9045	Carboplatin injection		K	0811		13.74		2.75
J9050	Carmus bischl nitro inj		K	0812		139.66		27.93
J9055	Cetuximab injection	CH	K	9215		49.39		9.88
J9060	Cisplatin 10 MG injection		N					
J9065	Inj cladribine per 1 MG		K	0858		38.28		7.66
J9070	Cyclophosphamide 100 MG inj		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9093	Cyclophosphamide lyophilized	CH	K	3049		5.47		1.09
J9098	Cytarabine liposome		K	1166		374.75		74.95
J9100	Cytarabine hcl 100 MG inj		N					
J9120	Dactinomycin actinomycin d		N					
J9130	Dacarbazine 100 mg inj	CH	N					
J9150	Daunorubicin		K	0820		23.36		4.67
J9151	Daunorubicin citrate liposom		K	0821		55.72		11.14
J9160	Denileukin diftitox, 300 mcg		K	1084		1,391.05		278.21
J9165	Diethylstilbestrol injection		N					
J9170	Docetaxel		K	0823		294.48		58.90
J9175	Elliotts b solution per ml		N					
J9178	Inj, epirubicin hcl, 2 mg		K	1167		24.47		4.89
J9181	Etoposide 10 MG inj		N					
J9185	Fludarabine phosphate inj		K	0842		230.11		46.02
J9190	Fluorouracil injection		N					
J9200	Floxuridine injection		K	0827		62.61		12.52
J9201	Gemcitabine HCl		K	0828		116.59		23.32
J9202	Goserelin acetate implant		K	0810		197.59		39.52
J9206	Irinotecan injection		K	0830		125.28		25.06
J9208	Ifosfomide injection		K	0831		54.19		10.84
J9209	Mesna injection		K	0732		7.87		1.57
J9211	Idarubicin hcl injection		K	0832		265.53		53.11
J9212	Interferon alfacon-1		K	0912		3.92		0.78
J9213	Interferon alfa-2a inj		K	0834		33.53		6.71
J9214	Interferon alfa-2b inj		K	0836		13.54		2.71
J9215	Interferon alfa-n3 inj		K	0865		50.33		10.07
J9216	Interferon gamma 1-b inj		K	0838		289.87		57.97
J9217	Leuprolide acetate suspnsion		K	9217		242.99		48.60
J9218	Leuprolide acetate injeciton		K	0861		7.86		1.57
J9219	Leuprolide acetate implant		K	7051		2,157.81		431.56
J9225	Histrelin implant		K	1711		2,019.82		403.96
J9230	Mechlorethamine hcl inj		N					
J9245	Inj melphalan hydrochl 50 MG		K	0840		1,190.81		238.16
J9250	Methotrexate sodium inj		N					
J9263	Oxaliplatin		K	1738		8.47		1.69
J9264	Paclitaxel injection		G	1712		8.73		1.75
J9265	Paclitaxel injection		K	0863		15.44		3.09
J9266	Pegaspargase/singl dose vial		K	0843		1,596.00		319.20
J9268	Pentostatin injection		K	0844		2,000.96		400.19
J9270	Plicamycin (mithramycin) inj		K	0860		173.66		34.73
J9280	Mitomycin 5 MG inj		K	0862		18.82		3.76
J9293	Mitoxantrone hydrochl/5 MG		K	0864		336.76		67.35
J9300	Gemtuzumab ozogamicin		K	9004		2,265.57		453.11
J9305	Pemetrexed injection	CH	K	9213		40.90		8.18
J9310	Rituximab cancer treatment		K	0849		465.23		93.05
J9320	Streptozocin injection		K	0850		147.45		29.49
J9340	Thiotepa injection		K	0851		45.38		9.08
J9350	Topotecan		K	0852		780.54		156.11
J9355	Trastuzumab		K	1613		54.59		10.92
J9357	Valrubicin, 200 mg		K	9167		76.03		15.21
J9360	Vinblastine sulfate inj		N					
J9370	Vincristine sulfate 1 MG inj		N					
J9390	Vinorelbine tartrate/10 mg		K	0855		22.04		4.41
J9395	Injection, Fulvestrant		K	9120		80.31		16.06
J9600	Porfimer sodium		K	0856		2,481.76		496.35
J9999	Chemotherapy drug		N					
L8600	Implant breast silicone/eq		N					
L8603	Collagen imp urinary 2.5 ml		N					
L8606	Synthetic implnt urinary 1ml		N					
L8609	Artificial cornea		N					
L8610	Ocular implant		N					
L8612	Aqueous shunt prosthesis		N					
L8613	Ossicular implant		N					
L8614	Cochlear device/system		N					
L8630	Metacarpophalangeal implant		N					
L8631	MCP joint repl 2 pc or more		N					
L8641	Metatarsal joint implant		N					
L8642	Hallux implant		N					
L8658	Interphalangeal joint spacer		N					
L8659	Interphalangeal joint repl		N					

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L8670	Vascular graft, synthetic		N					
L8682	Implt neurostim radiofq rec		N					
L8699	Prosthetic implant NOS		N					
M0064	Visit for drug monitoring		X	0374	1.1509	70.84		14.17
P9010	Whole blood for transfusion		K	0950	2.1824	134.33		26.87
P9011	Blood split unit		K	0967	2.2087	135.95		27.19
P9012	Cryoprecipitate each unit		K	0952	0.8571	52.76		10.55
P9016	RBC leukocytes reduced		K	0954	2.8738	176.89		35.38
P9017	Plasma 1 donor frz w/in 8 hr		K	9508	1.1677	71.87		14.37
P9019	Platelets, each unit		K	0957	0.9794	60.28		12.06
P9020	Plaelet rich plasma unit		K	0958	2.5336	155.95		31.19
P9021	Red blood cells unit		K	0959	2.1045	129.53		25.91
P9022	Washed red blood cells unit		K	0960	3.5028	215.60		43.12
P9023	Frozen plasma, pooled, sd		K	0949	0.9060	55.77		11.15
P9031	Platelets leukocytes reduced		K	1013	1.5318	94.28		18.86
P9032	Platelets, irradiated		K	9500	2.0957	128.99		25.80
P9033	Platelets leukoreduced irrad		K	0968	2.1192	130.44		26.09
P9034	Platelets, pheresis		K	9507	7.5381	463.98		92.80
P9035	Platelet pheres leukoreduced		K	9501	7.9414	488.80		97.76
P9036	Platelet pheresis irradiated		K	9502	6.6959	412.14		82.43
P9037	Plate pheres leukoredu irrad		K	1019	9.9841	614.53		122.91
P9038	RBC irradiated		K	9505	3.2600	200.66		40.13
P9039	RBC deglycerolized		K	9504	5.7106	351.49		70.30
P9040	RBC leukoreduced irradiated		K	0969	3.7037	227.97		45.59
P9041	Albumin (human),5%, 50ml		K	0961		25.48		5.10
P9043	Plasma protein fract,5%,50ml		K	0956	0.4016	24.72		4.94
P9044	Cryoprecipitatereducedplasma		K	1009	1.2990	79.95		15.99
P9045	Albumin (human), 5%, 250 ml		K	0963		72.09		14.42
P9046	Albumin (human), 25%, 20 ml		K	0964		26.79		5.36
P9047	Albumin (human), 25%, 50ml		K	0965		61.77		12.35
P9048	Plasmaprotein fract,5%,250ml		K	0966	3.1309	192.71		38.54
P9050	Granulocytes, pheresis unit		K	9506	4.1030	252.54		50.51
P9051	Blood, l/r, cmv-neg		K	1010	2.1991	135.36		27.07
P9052	Platelets, hla-m, l/r, unit		K	1011	10.5084	646.80		129.36
P9053	Plt, pher, l/r cmv-neg, irr		K	1020	11.7025	720.30		144.06
P9054	Blood, l/r, froz/degly/wash		K	1016	1.4462	89.02		17.80
P9055	Plt, aph/pher, l/r, cmv-neg		K	1017	6.1508	378.59		75.72
P9056	Blood, l/r, irradiated		K	1018	2.1765	133.97		26.79
P9057	RBC, frz/deg/wsh, l/r, irrad		K	1021	6.9189	425.87		85.17
P9058	RBC, l/r, cmv-neg, irrad		K	1022	4.2818	263.55		52.71
P9059	Plasma, frz between 8-24hour		K	0955	1.1864	73.02		14.60
P9060	Fr frz plasma donor retested		K	9503	1.1915	73.34		14.67
P9612	Catheterize for urine spec	CH	A					
P9615	Urine specimen collect mult		N					
Q0035	Cardiokymography		X	0100	2.5352	156.04	41.44	31.21
Q0091	Obtaining screen pap smear		T	0191	0.1501	9.24		1.85
Q0092	Set up port xray equipment		N					
Q0163	Diphenhydramine HCl 50mg		N					
Q0164	Prochlorperazine maleate 5mg		N					
Q0166	Granisetron HCl 1 mg oral		K	0765		37.08		7.42
Q0167	Dronabinol 2.5mg oral		N					
Q0169	Promethazine HCl 12.5mg oral		N					
Q0171	Chlorpromazine HCl 10mg oral		N					
Q0173	Trimethobenzamide HCl 250mg		N					
Q0174	Thiethylperazine maleate10mg		N					
Q0175	Perphenazine 4mg oral		N					
Q0177	Hydroxyzine pamoate 25mg		N					
Q0179	Ondansetron HCl 8mg oral		K	0769		34.21		6.84
Q0180	Dolasetron mesylate oral		K	0763		47.52		9.50
Q0512	Px sup fee anti-can sub pres	CH	B					
Q0515	Sermorelin acetate injection	CH	K	3050		1.73		0.35
Q1003	Ntiol category 3		N					
Q1004	Ntiol category 4		N					
Q1005	Ntiol category 5		N					
Q2004	Bladder calculi irrig sol		N					
Q2009	Fosphenytoin, 50 mg		K	7028		5.18		1.04
Q2017	Teniposide, 50 mg		K	7035		264.26		52.85
Q3019	ALS emer trans no ALS serv	CH	E					
Q3020	ALS nonemer trans no ALS ser	CH	E					
Q3025	IM inj interferon beta 1-a		K	9022		97.99		19.60

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2007—Continued

CPT/ HCPCS	Description	CI	SI	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q3031	Collagen skin test		N					
Q4079	Natalizumab injection		G	9126		6.39		1.28
Q9945	LOCM <=149 mg/ml iodine, 1ml		K	9157		0.30		0.06
Q9946	LOCM 150–199mg/ml iodine,1ml		K	9158		1.84		0.37
Q9947	LOCM 200–249mg/ml iodine,1ml		K	9159		1.25		0.25
Q9948	LOCM 250–299mg/ml iodine,1ml		K	9160		0.32		0.06
Q9949	LOCM 300–349mg/ml iodine,1ml		K	9161		0.34		0.07
Q9950	LOCM 350–399mg/ml iodine,1ml		K	9162		0.21		0.04
Q9951	LOCM >= 400 mg/ml iodine,1ml		K	9163		0.30		0.06
Q9952	Inj Gad-base MR contrast,1ml		K	9164		2.88		0.58
Q9953	Inj Fe-based MR contrast,1ml		K	1713		30.12		6.02
Q9954	Oral MR contrast, 100 ml		K	9165		8.87		1.77
Q9955	Inj perflexane lip micros,ml		K	9203		8.22		1.64
Q9956	Inj octafluoropropane mic,ml		K	9202		40.75		8.15
Q9957	Inj perflutren lip micros,ml		K	9112		61.25		12.25
Q9958	HOCM <=149 mg/ml iodine, 1ml	CH	N					
Q9959	HOCM 150–199mg/ml iodine,1ml		N					
Q9960	HOCM 200–249mg/ml iodine,1ml	CH	N					
Q9961	HOCM 250–299mg/ml iodine,1ml	CH	N					
Q9962	HOCM 300–349mg/ml iodine,1ml	CH	N					
Q9963	HOCM 350–399mg/ml iodine,1ml	CH	N					
Q9964	HOCM>= 400mg/ml iodine, 1ml	CH	N					
V2630	Anter chamber intraocul lens		N					
V2631	Iris support intraoclr lens		N					
V2632	Post chmbr intraocular lens		N					
V2790	Amniotic membrane		N					

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
10021	Fna w/o image	Y	Y		1.0948	$43.45	$43.45	$8.69	$8.69
10022	Fna w/image	Y			2.0147	$79.96	$79.96	$15.99	$15.99
10040	Acne surgery	Y	Y		0.4829	$19.17	$19.17	$3.83	$3.83
10060	Drainage of skin abscess.	Y	Y	Y	1.1457	$45.47	$45.47	$9.09	$9.09
10061	Drainage of skin abscess.	Y	Y		1.4821	$58.82	$58.82	$11.76	$11.76
10080	Drainage of pilonidal cyst.	Y	Y		1.4821	$58.82	$58.82	$11.76	$11.76
10081	Drainage of pilonidal cyst.	Y	Y	Y	3.2148	$127.59	$127.59	$25.52	$25.52
10120	Remove foreign body.	Y	Y		1.4821	$58.82	$58.82	$11.76	$11.76
10121	Remove foreign body.				14.9563	$593.59	$519.79	$118.72	$103.96
10140	Drainage of hematoma/fluid.	Y	Y	Y	1.7090	$67.83	$67.83	$13.57	$13.57
10160	Puncture drainage of lesion.	Y	Y		1.0534	$41.81	$41.81	$8.36	$8.36
10180	Complex drainage, wound.				17.4686	$693.30	$569.65	$138.66	$113.93
11000	Debride infected skin.	Y	Y	Y	0.5503	$21.84	$21.84	$4.37	$4.37
11001	Debride infected skin add-on.	Y	Y	Y	0.1942	$7.71	$7.71	$1.54	$1.54
11010	Debride skin, fx				4.0123	$159.24	$203.10	$31.85	$40.62
11011	Debride skin/muscle, fx.				4.0123	$159.24	$203.10	$31.85	$40.62
11012	Debride skin/muscle/bone, fx.				4.0123	$159.24	$203.10	$31.85	$40.62
11040	Debride skin, partial.	Y	Y	Y	0.5040	$20.00	$20.00	$4.00	$4.00

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
11041	Debride skin, full.	Y	Y	Y	0.6042	$23.98	$23.98	$4.80	$4.80
11042	Debride skin/tissue.				2.6253	$104.19	$132.89	$20.84	$26.58
11043	Debride tissue/muscle.				2.6253	$104.19	$132.89	$20.84	$26.58
11044	Debride tissue/muscle/bone.				6.7529	$268.01	$341.83	$53.60	$68.37
11055	Trim skin lesion	Y	Y	Y	0.5762	$22.87	$22.87	$4.57	$4.57
11056	Trim skin lesions, 2 to 4.	Y	Y	Y	0.6403	$25.41	$25.41	$5.08	$5.08
11057	Trim skin lesions, over 4.	Y	Y	Y	0.7268	$28.85	$28.85	$5.77	$5.77
11100	Biopsy, skin lesion.	Y	Y		1.0534	$41.81	$41.81	$8.36	$8.36
11101	Biopsy, skin add-on.	Y	Y	Y	0.3217	$12.77	$12.77	$2.55	$2.55
11200	Removal of skin tags.	Y	Y	Y	0.9713	$38.55	$38.55	$7.71	$7.71
11201	Remove skin tags add-on.	Y	Y	Y	0.1365	$5.42	$5.42	$1.08	$1.08
11300	Shave skin lesion.	Y	Y		0.8076	$32.05	$32.05	$6.41	$6.41
11301	Shave skin lesion.	Y	Y		0.8076	$32.05	$32.05	$6.41	$6.41
11302	Shave skin lesion.	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
11303	Shave skin lesion.	Y	Y	Y	1.5547	$61.70	$61.70	$12.34	$12.34
11305	Shave skin lesion.	Y	Y	Y	0.8112	$32.20	$32.20	$6.44	$6.44
11306	Shave skin lesion.	Y	Y	Y	1.0789	$42.82	$42.82	$8.56	$8.56
11307	Shave skin lesion.	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
11308	Shave skin lesion.	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
11310	Shave skin lesion.	Y	Y	Y	1.0785	$42.80	$42.80	$8.56	$8.56
11311	Shave skin lesion.	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
11312	Shave skin lesion.	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
11313	Shave skin lesion.	Y	Y	Y	1.7299	$68.66	$68.66	$13.73	$13.73
11400	Removal of skin lesion.	Y	Y	Y	1.6618	$65.96	$65.96	$13.19	$13.19
11401	Removal of skin lesion.	Y	Y	Y	1.8178	$72.14	$72.14	$14.43	$14.43
11402	Removal of skin lesion.	Y	Y	Y	1.9768	$78.45	$78.45	$15.69	$15.69
11403	Removal of skin lesion.	Y	Y	Y	2.1118	$83.81	$83.81	$16.76	$16.76
11404	Exc tr-ext b9+marg 3.1-4 cm.				14.9563	$593.59	$463.29	$118.72	$92.66
11406	Exc tr-ext b9+marg > 4.0 cm.				14.9563	$593.59	$519.79	$118.72	$103.96
11420	Removal of skin lesion.	Y	Y	Y	1.5323	$60.81	$60.81	$12.16	$12.16
11421	Removal of skin lesion.	Y	Y	Y	1.8294	$72.61	$72.61	$14.52	$14.52
11422	Removal of skin lesion.	Y	Y	Y	1.9996	$79.36	$79.36	$15.87	$15.87
11423	Removal of skin lesion.	Y	Y	Y	2.2405	$88.92	$88.92	$17.78	$17.78

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
11424	Exc h-f-nk-sp b9+marg 3.1-4.				14.9563	$593.59	$519.79	$118.72	$103.96
11426	Exc h-f-nk-sp b9+marg > 4 cm.				19.9760	$792.81	$619.40	$158.56	$123.88
11440	Removal of skin lesion.	Y	Y	Y	1.8212	$72.28	$72.28	$14.46	$14.46
11441	Removal of skin lesion.	Y	Y	Y	2.0319	$80.64	$80.64	$16.13	$16.13
11442	Removal of skin lesion.	Y	Y	Y	2.2205	$88.13	$88.13	$17.63	$17.63
11443	Removal of skin lesion.	Y	Y	Y	2.4880	$98.75	$98.75	$19.75	$19.75
11444	Exc face-mm b9+marg 3.1-4 cm.				6.5128	$258.48	$295.74	$51.70	$59.15
11446	Exc face-mm b9+marg > 4 cm.				19.9760	$792.81	$619.40	$158.56	$123.88
11450	Removal, sweat gland lesion.				19.9760	$792.81	$619.40	$158.56	$123.88
11451	Removal, sweat gland lesion.				19.9760	$792.81	$619.40	$158.56	$123.88
11462	Removal, sweat gland lesion.				19.9760	$792.81	$619.40	$158.56	$123.88
11463	Removal, sweat gland lesion.				19.9760	$792.81	$619.40	$158.56	$123.88
11470	Removal, sweat gland lesion.				19.9760	$792.81	$619.40	$158.56	$123.88
11471	Removal, sweat gland lesion.				19.9760	$792.81	$619.40	$158.56	$123.88
11600	Removal of skin lesion.	Y	Y	Y	2.2612	$89.74	$89.74	$17.95	$17.95
11601	Removal of skin lesion.	Y	Y	Y	2.5980	$103.11	$103.11	$20.62	$20.62
11602	Removal of skin lesion.	Y	Y	Y	2.8188	$111.87	$111.87	$22.37	$22.37
11603	Removal of skin lesion.	Y	Y	Y	3.0099	$119.46	$119.46	$23.89	$23.89
11604	Exc tr-ext mlg+marg 3.1-4 cm.				6.5128	$258.48	$329.68	$51.70	$65.94
11606	Exc tr-ext mlg+marg > 4 cm.				14.9563	$593.59	$519.79	$118.72	$103.96
11620	Removal of skin lesion.	Y	Y	Y	2.2902	$90.89	$90.89	$18.18	$18.18
11621	Removal of skin lesion.	Y	Y	Y	2.6216	$104.05	$104.05	$20.81	$20.81
11622	Removal of skin lesion.	Y	Y	Y	2.9059	$115.33	$115.33	$23.07	$23.07
11623	Removal of skin lesion.	Y	Y	Y	3.1563	$125.27	$125.27	$25.05	$25.05
11624	Exc h-f-nk-sp mlg+marg 3.1-4.				14.9563	$593.59	$519.79	$118.72	$103.96
11626	Exc h-f-nk-sp mlg+mar > 4 cm.				19.9760	$792.81	$619.40	$158.56	$123.88
11640	Removal of skin lesion.	Y	Y	Y	2.4089	$95.60	$95.60	$19.12	$19.12
11641	Removal of skin lesion.	Y	Y	Y	2.8188	$111.87	$111.87	$22.37	$22.37
11642	Removal of skin lesion.	Y	Y	Y	3.1554	$125.23	$125.23	$25.05	$25.05
11643	Removal of skin lesion.	Y	Y	Y	3.4305	$136.15	$136.15	$27.23	$27.23

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
11644	Exc face-mm malig+marg 3.1-4.				14.9563	$593.59	$519.79	$118.72	$103.96
11646	Exc face-mm mlg+marg > 4 cm.				19.9760	$792.81	$619.40	$158.56	$123.88
11719	Trim nail(s)	Y	Y	Y	0.2643	$10.49	$10.49	$2.10	$2.10
11720	Debride nail, 1-5.	Y	Y	Y	0.3393	$13.47	$13.47	$2.69	$2.69
11721	Debride nail, 6 or more.	Y	Y	Y	0.4134	$16.41	$16.41	$3.28	$3.28
11730	Removal of nail plate.	Y	Y	Y	0.9967	$39.56	$39.56	$7.91	$7.91
11732	Remove nail plate, add-on.	Y	Y	Y	0.4138	$16.42	$16.42	$3.28	$3.28
11740	Drain blood from under nail.	Y	Y	Y	0.5675	$22.52	$22.52	$4.50	$4.50
11750	Removal of nail bed.	Y	Y	Y	2.1520	$85.41	$85.41	$17.08	$17.08
11752	Remove nail bed/finger tip.	Y	Y	Y	3.0179	$119.78	$119.78	$23.96	$23.96
11755	Biopsy, nail unit	Y	Y	Y	1.5236	$60.47	$60.47	$12.09	$12.09
11760	Repair of nail bed.	Y			1.4924	$59.23	$59.23	$11.85	$11.85
11762	Reconstruction of nail bed.	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
11765	Excision of nail fold, toe.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
11770	Removal of pilonidal lesion.				19.9760	$792.81	$651.40	$158.56	$130.28
11771	Removal of pilonidal lesion.				19.9760	$792.81	$651.40	$158.56	$130.28
11772	Removal of pilonidal lesion.				19.9760	$792.81	$651.40	$158.56	$130.28
11900	Injection into skin lesions.	Y	Y	Y	0.6789	$26.94	$26.94	$5.39	$5.39
11901	Added skin lesions injection.	Y	Y	Y	0.7259	$28.81	$28.81	$5.76	$5.76
11920	Correct skin color defects.	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
11921	Correct skin color defects.	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
11922	Correct skin color defects.	Y	Y	Y	0.8864	$35.18	$35.18	$7.04	$7.04
11950	Therapy for contour defects.	Y	Y	Y	0.8811	$34.97	$34.97	$6.99	$6.99
11951	Therapy for contour defects.	Y	Y	Y	1.1485	$45.58	$45.58	$9.12	$9.12
11952	Therapy for contour defects.	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
11954	Therapy for contour defects.	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
11960	Insert tissue expander(s).				21.2645	$843.95	$644.97	$168.79	$128.99
11970	Replace tissue expander.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
11971	Remove tissue expander(s).				19.9760	$792.81	$562.90	$158.56	$112.58
11976	Removal of contraceptive cap.	Y	Y	Y	1.4625	$58.04	$58.04	$11.61	$11.61

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
11980	Implant hormone pellet(s).	Y	Y		0.6211	$24.65	$24.65	$4.93	$4.93
11981	Insert drug implant device.	Y	Y		0.6211	$24.65	$24.65	$4.93	$4.93
11982	Remove drug implant device.	Y	Y		0.6211	$24.65	$24.65	$4.93	$4.93
11983	Remove/insert drug implant.	Y	Y		0.6211	$24.65	$24.65	$4.93	$4.93
12001	Repair superficial wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
12002	Repair superficial wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
12004	Repair superficial wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
12005	Repair superficial wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12006	Repair superficial wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12007	Repair superficial wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12011	Repair superficial wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
12013	Repair superficial wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
12014	Repair superficial wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
12015	Repair superficial wound(s).	Y			1.4924	$59.23	$59.23	$11.85	$11.85
12016	Repair superficial wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12017	Repair superficial wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12018	Repair superficial wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12020	Closure of split wound.				1.4924	$59.23	$75.55	$11.85	$15.11
12021	Closure of split wound.				1.4924	$59.23	$75.55	$11.85	$15.11
12031	Layer closure of wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
12032	Layer closure of wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
12034	Layer closure of wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12035	Layer closure of wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12036	Layer closure of wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12037	Layer closure of wound(s).				5.0931	$202.14	$257.81	$40.43	$51.56
12041	Layer closure of wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
12042	Layer closure of wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
12044	Layer closure of wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12045	Layer closure of wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12046	Layer closure of wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12047	Layer closure of wound(s).				5.0931	$202.14	$257.81	$40.43	$51.56
12051	Layer closure of wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
12052	Layer closure of wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
12053	Layer closure of wound(s).	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
12054	Layer closure of wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12055	Layer closure of wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12056	Layer closure of wound(s).				1.4924	$59.23	$75.55	$11.85	$15.11
12057	Layer closure of wound(s).				5.0931	$202.14	$257.81	$40.43	$51.56
13100	Repair of wound or lesion.				5.0931	$202.14	$257.81	$40.43	$51.56
13101	Repair of wound or lesion.				5.0931	$202.14	$257.81	$40.43	$51.56
13102	Repair wound/lesion add-on.	Y			1.4924	$59.23	$59.23	$11.85	$11.85
13120	Repair of wound or lesion.				1.4924	$59.23	$75.55	$11.85	$15.11
13121	Repair of wound or lesion.				1.4924	$59.23	$75.55	$11.85	$15.11
13122	Repair wound/lesion add-on.	Y			1.4924	$59.23	$59.23	$11.85	$11.85
13131	Repair of wound or lesion.				1.4924	$59.23	$75.55	$11.85	$15.11
13132	Repair of wound or lesion.				1.4924	$59.23	$75.55	$11.85	$15.11
13133	Repair wound/lesion add-on.	Y	Y		1.4924	$59.23	$59.23	$11.85	$11.85
13150	Repair of wound or lesion.				5.0931	$202.14	$257.81	$40.43	$51.56
13151	Repair of wound or lesion.				1.4924	$59.23	$75.55	$11.85	$15.11
13152	Repair of wound or lesion.				5.0931	$202.14	$257.81	$40.43	$51.56
13153	Repair wound/lesion add-on.	Y			1.4924	$59.23	$59.23	$11.85	$11.85
13160	Late closure of wound.				21.2645	$843.95	$644.97	$168.79	$128.99
14000	Skin tissue rearrangement.				13.3433	$529.57	$487.79	$105.91	$97.56
14001	Skin tissue rearrangement.				21.2645	$843.95	$676.97	$168.79	$135.39
14020	Skin tissue rearrangement.				13.3433	$529.57	$519.79	$105.91	$103.96
14021	Skin tissue rearrangement.				13.3433	$529.57	$519.79	$105.91	$103.96
14040	Skin tissue rearrangement.				13.3433	$529.57	$487.79	$105.91	$97.56
14041	Skin tissue rearrangement.				13.3433	$529.57	$519.79	$105.91	$103.96
14060	Skin tissue rearrangement.				13.3433	$529.57	$519.79	$105.91	$103.96
14061	Skin tissue rearrangement.				13.3433	$529.57	$519.79	$105.91	$103.96
14300	Skin tissue rearrangement.				21.2645	$843.95	$736.97	$168.79	$147.39

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
14350	Skin tissue rearrangement.				21.2645	$843.95	$676.97	$168.79	$135.39
15000	Wound prep, 1st 100 sq cm.				5.0931	$202.14	$257.81	$40.43	$51.56
15001	Wound prep, addl 100 sq cm.				5.0931	$202.14	$257.81	$40.43	$51.56
15040	Harvest cultured skin graft.				1.4924	$59.23	$75.55	$11.85	$15.11
15050	Skin pinch graft				5.0931	$202.14	$257.81	$40.43	$51.56
15100	Skin splt grft, trnk/arm/leg.				21.2645	$843.95	$644.97	$168.79	$128.99
15101	Skin splt grft t/a/l, add-on.				21.2645	$843.95	$676.97	$168.79	$135.39
15110	Epidrm autogrft trnk/arm/leg.				21.2645	$843.95	$644.97	$168.79	$128.99
15111	Epidrm autogrft t/a/l add-on.				21.2645	$843.95	$588.47	$168.79	$117.69
15115	Epidrm a-grft face/nck/hf/g.				21.2645	$843.95	$644.97	$168.79	$128.99
15116	Epidrm a-grft f/n/hf/g addl.				21.2645	$843.95	$588.47	$168.79	$117.69
15120	Skn splt a-grft fac/nck/hf/g.				21.2645	$843.95	$644.97	$168.79	$128.99
15121	Skn splt a-grft f/n/hf/g add.				21.2645	$843.95	$676.97	$168.79	$135.39
15130	Derm autograft, trnk/arm/leg.				21.2645	$843.95	$644.97	$168.79	$128.99
15131	Derm autograft t/a/l add-on.				21.2645	$843.95	$588.47	$168.79	$117.69
15135	Derm autograft face/nck/hf/g.				21.2645	$843.95	$644.97	$168.79	$128.99
15136	Derm autograft, f/n/hf/g add.				21.2645	$843.95	$588.47	$168.79	$117.69
15150	Cult epiderm grft t/arm/leg.				21.2645	$843.95	$644.97	$168.79	$128.99
15151	Cult epiderm grft t/a/l addl.				21.2645	$843.95	$588.47	$168.79	$117.69
15152	Cult epiderm graft t/a/l +%.				21.2645	$843.95	$588.47	$168.79	$117.69
15155	Cult epiderm graft, f/n/hf/g.				21.2645	$843.95	$644.97	$168.79	$128.99
15156	Cult epidrm grft f/n/hfg add.				21.2645	$843.95	$588.47	$168.79	$117.69
15157	Cult epiderm grft f/n/hfg +%.				21.2645	$843.95	$588.47	$168.79	$117.69
15200	Skin full graft, trunk.				13.3433	$529.57	$519.79	$105.91	$103.96
15201	Skin full graft trunk add-on.				5.0931	$202.14	$257.81	$40.43	$51.56
15220	Skin full graft sclp/arm/leg.				13.3433	$529.57	$487.79	$105.91	$97.56
15221	Skin full graft add-on.				5.0931	$202.14	$257.81	$40.43	$51.56
15240	Skin full grft face/genit/hf.				13.3433	$529.57	$519.79	$105.91	$103.96
15241	Skin full graft add-on.				5.0931	$202.14	$257.81	$40.43	$51.56
15260	Skin full graft een & lips.				13.3433	$529.57	$487.79	$105.91	$97.56
15261	Skin full graft add-on.				5.0931	$202.14	$257.81	$40.43	$51.56
15300	Apply skinallogrft, t/arm/lg.				5.0931	$202.14	$257.81	$40.43	$51.56
15301	Apply sknallogrft t/a/l addl.				5.0931	$202.14	$257.81	$40.43	$51.56

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
15320	Apply skin allogrft f/n/hf/g.				5.0931	$202.14	$257.81	$40.43	$51.56
15321	Aply sknallogrft f/n/hfg add.				5.0931	$202.14	$257.81	$40.43	$51.56
15330	Aply acell alogrft t/arm/leg.				5.0931	$202.14	$257.81	$40.43	$51.56
15331	Aply acell grft t/a/l add-on.				5.0931	$202.14	$257.81	$40.43	$51.56
15335	Apply acell graft, f/n/hf/g.				5.0931	$202.14	$257.81	$40.43	$51.56
15336	Aply acell grft f/n/hf/g add.				5.0931	$202.14	$257.81	$40.43	$51.56
15340	Apply cult skin substitute.	Y	Y	Y	3.2865	$130.44	$130.44	$26.09	$26.09
15341	Apply cult skin sub add-on.	Y			5.0931	$202.14	$202.14	$40.43	$40.43
15360	Apply cult derm sub, t/a/l.	Y			5.0931	$202.14	$202.14	$40.43	$40.43
15361	Aply cult derm sub t/a/l add.	Y			5.0931	$202.14	$202.14	$40.43	$40.43
15365	Apply cult derm sub f/n/hf/g.	Y			5.0931	$202.14	$202.14	$40.43	$40.43
15366	Apply cult derm f/hf/g add.	Y			5.0931	$202.14	$202.14	$40.43	$40.43
15400	Apply skin xenograft, t/a/l.				5.0931	$202.14	$257.81	$40.43	$51.56
15401	Apply skn xenogrft t/a/l add.				5.0931	$202.14	$257.81	$40.43	$51.56
15420	Apply skin xgraft, f/n/hf/g.				5.0931	$202.14	$257.81	$40.43	$51.56
15421	Apply skn xgrft f/n/hf/g add.				5.0931	$202.14	$257.81	$40.43	$51.56
15430	Apply acellular xenograft.				5.0931	$202.14	$257.81	$40.43	$51.56
15431	Apply acellular xgraft add.				5.0931	$202.14	$257.81	$40.43	$51.56
15570	Form skin pedicle flap.				21.2645	$843.95	$676.97	$168.79	$135.39
15572	Form skin pedicle flap.				21.2645	$843.95	$676.97	$168.79	$135.39
15574	Form skin pedicle flap.				21.2645	$843.95	$676.97	$168.79	$135.39
15576	Form skin pedicle flap.				13.3433	$529.57	$519.79	$105.91	$103.96
15600	Skin graft				21.2645	$843.95	$676.97	$168.79	$135.39
15610	Skin graft				21.2645	$843.95	$676.97	$168.79	$135.39
15620	Skin graft				21.2645	$843.95	$736.97	$168.79	$147.39
15630	Skin graft				21.2645	$843.95	$676.97	$168.79	$135.39
15650	Transfer skin pedicle flap.				21.2645	$843.95	$780.47	$168.79	$156.09
15732	Muscle-skin graft, head/neck.				21.2645	$843.95	$676.97	$168.79	$135.39
15734	Muscle-skin graft, trunk.				21.2645	$843.95	$676.97	$168.79	$135.39
15736	Muscle-skin graft, arm.				21.2645	$843.95	$676.97	$168.79	$135.39
15738	Muscle-skin graft, leg.				21.2645	$843.95	$676.97	$168.79	$135.39
15740	Island pedicle flap graft.				13.3433	$529.57	$487.79	$105.91	$97.56
15750	Neurovascular pedicle graft.				21.2645	$843.95	$644.97	$168.79	$128.99
15760	Composite skin graft.				21.2645	$843.95	$644.97	$168.79	$128.99

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
15770	Derma-fat-fascia graft.				21.2645	$843.95	$676.97	$168.79	$135.39
15775	Hair transplant punch grafts.				5.0931	$202.14	$257.81	$40.43	$51.56
15776	Hair transplant punch grafts.				5.0931	$202.14	$257.81	$40.43	$51.56
15780	Abrasion treatment of skin.	Y	Y	Y	10.0118	$397.35	$397.35	$79.47	$79.47
15781	Abrasion treatment of skin.	Y	Y		4.0123	$159.24	$159.24	$31.85	$31.85
15782	Dressing change not for burn.	Y	Y		4.0123	$159.24	$159.24	$31.85	$31.85
15783	Abrasion treatment of skin.	Y	Y		2.6253	$104.19	$104.19	$20.84	$20.84
15786	Abrasion, lesion, single.	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
15787	Abrasion, lesions, add-on.	Y	Y	Y	0.8221	$32.63	$32.63	$6.53	$6.53
15788	Chemical peel, face, epiderm.	Y	Y		0.8076	$32.05	$32.05	$6.41	$6.41
15789	Chemical peel, face, dermal.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
15792	Chemical peel, nonfacial.	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
15793	Chemical peel, nonfacial.	Y	Y		0.8076	$32.05	$32.05	$6.41	$6.41
15819	Plastic surgery, neck.	Y			5.0931	$202.14	$202.14	$40.43	$40.43
15820	Revision of lower eyelid.				21.2645	$843.95	$676.97	$168.79	$135.39
15821	Revision of lower eyelid.				21.2645	$843.95	$676.97	$168.79	$135.39
15822	Revision of upper eyelid.				21.2645	$843.95	$676.97	$168.79	$135.39
15823	Revision of upper eyelid.				13.3433	$529.57	$623.29	$105.91	$124.66
15824	Removal of forehead wrinkles.				21.2645	$843.95	$676.97	$168.79	$135.39
15825	Removal of neck wrinkles.				21.2645	$843.95	$676.97	$168.79	$135.39
15826	Removal of brow wrinkles.				21.2645	$843.95	$676.97	$168.79	$135.39
15828	Removal of face wrinkles.				21.2645	$843.95	$676.97	$168.79	$135.39
15829	Removal of skin wrinkles.				21.2645	$843.95	$780.47	$168.79	$156.09
15831	Excise excessive skin tissue.				19.9760	$792.81	$651.40	$158.56	$130.28
15832	Excise excessive skin tissue.				19.9760	$792.81	$651.40	$158.56	$130.28
15833	Excise excessive skin tissue.				19.9760	$792.81	$651.40	$158.56	$130.28
15834	Excise excessive skin tissue.				19.9760	$792.81	$651.40	$158.56	$130.28
15835	Excise excessive skin tissue.				5.0931	$202.14	$257.81	$40.43	$51.56
15836	Excise excessive skin tissue.				14.9563	$593.59	$551.79	$118.72	$110.36

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
15837	Excise excessive skin tissue.	Y			14.9563	$593.59	$593.59	$118.72	$118.72
15838	Excise excessive skin tissue.	Y			14.9563	$593.59	$593.59	$118.72	$118.72
15839	Excise excessive skin tissue.				14.9563	$593.59	$551.79	$118.72	$110.36
15840	Graft for face nerve palsy.				21.2645	$843.95	$736.97	$168.79	$147.39
15841	Graft for face nerve palsy.				21.2645	$843.95	$736.97	$168.79	$147.39
15845	Skin and muscle repair, face.				21.2645	$843.95	$736.97	$168.79	$147.39
15850	Removal of sutures.	Y			2.6253	$104.19	$104.19	$20.84	$20.84
15851	Removal of sutures.	Y	Y	Y	1.2829	$50.92	$50.92	$10.18	$10.18
15852	Dressing change not for burn.	Y			0.6211	$24.65	$24.65	$4.93	$4.93
15860	Test for blood flow in graft.	Y			0.6211	$24.65	$24.65	$4.93	$4.93
15876	Suction assisted lipectomy.				21.2645	$843.95	$676.97	$168.79	$135.39
15877	Suction assisted lipectomy.				21.2645	$843.95	$676.97	$168.79	$135.39
15878	Suction assisted lipectomy.				13.3433	$529.57	$519.79	$105.91	$103.96
15879	Suction assisted lipectomy.				21.2645	$843.95	$676.97	$168.79	$135.39
15920	Removal of tail bone ulcer.				4.0123	$159.24	$203.10	$31.85	$40.62
15922	Removal of tail bone ulcer.				21.2645	$843.95	$736.97	$168.79	$147.39
15931	Remove sacrum pressure sore.				19.9760	$792.81	$651.40	$158.56	$130.28
15933	Remove sacrum pressure sore.				19.9760	$792.81	$651.40	$158.56	$130.28
15934	Remove sacrum pressure sore.				21.2645	$843.95	$676.97	$168.79	$135.39
15935	Remove sacrum pressure sore.				21.2645	$843.95	$736.97	$168.79	$147.39
15936	Remove sacrum pressure sore.				21.2645	$843.95	$736.97	$168.79	$147.39
15937	Remove sacrum pressure sore.				21.2645	$843.95	$736.97	$168.79	$147.39
15940	Remove hip pressure sore.				19.9760	$792.81	$651.40	$158.56	$130.28
15941	Remove hip pressure sore.				19.9760	$792.81	$651.40	$158.56	$130.28
15944	Remove hip pressure sore.				21.2645	$843.95	$676.97	$168.79	$135.39
15945	Remove hip pressure sore.				21.2645	$843.95	$736.97	$168.79	$147.39
15946	Remove hip pressure sore.				21.2645	$843.95	$736.97	$168.79	$147.39
15950	Remove thigh pressure sore.				19.9760	$792.81	$651.40	$158.56	$130.28
15951	Remove thigh pressure sore.				19.9760	$792.81	$711.40	$158.56	$142.28
15952	Remove thigh pressure sore.				21.2645	$843.95	$676.97	$168.79	$135.39
15953	Remove thigh pressure sore.				21.2645	$843.95	$736.97	$168.79	$147.39

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
15956	Remove thigh pressure sore.				21.2645	$843.95	$676.97	$168.79	$135.39
15958	Remove thigh pressure sore.				21.2645	$843.95	$736.97	$168.79	$147.39
16000	Initial treatment of burn(s).	Y	Y	Y	0.6709	$26.63	$26.63	$5.33	$5.33
16020	Treatment of burn(s).	Y	Y	Y	1.0167	$40.35	$40.35	$8.07	$8.07
16025	Dress/debrid p-thick burn, m.				1.0876	$43.16	$55.05	$8.63	$11.01
16030	Dress/debrid p-thick burn, l.				1.6062	$63.75	$81.30	$12.75	$16.26
17000	Destroy benign/premlg lesion.	Y	Y		0.4829	$19.17	$19.17	$3.83	$3.83
17003	Destroy lesions, 2-14.	Y	Y	Y	0.0928	$3.68	$3.68	$0.74	$0.74
17004	Destroy lesions, 15 or more.	Y	Y	Y	2.0221	$80.25	$80.25	$16.05	$16.05
17106	Destruction of skin lesions.	Y	Y		2.6478	$105.09	$105.09	$21.02	$21.02
17107	Destruction of skin lesions.	Y	Y		2.6478	$105.09	$105.09	$21.02	$21.02
17108	Destruction of skin lesions.	Y	Y		2.6478	$105.09	$105.09	$21.02	$21.02
17110	Destruct lesion, 1-14.	Y	Y		0.8076	$32.05	$32.05	$6.41	$6.41
17111	Destruct lesion, 15 or more.	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
17250	Chemical cautery, tissue.	Y	Y	Y	1.0812	$42.91	$42.91	$8.58	$8.58
17260	Destruction of skin lesions.	Y	Y	Y	1.1651	$46.24	$46.24	$9.25	$9.25
17261	Destruction of skin lesions.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
17262	Destruction of skin lesions.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
17263	Destruction of skin lesions.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
17264	Destruction of skin lesions.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
17266	Destruction of skin lesions.	Y	Y	Y	2.6129	$103.70	$103.70	$20.74	$20.74
17270	Destruction of skin lesions.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
17271	Destruction of skin lesions.	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
17272	Destruction of skin lesions.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
17273	Destruction of skin lesions.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
17274	Destruction of skin lesions.	Y	Y		2.6253	$104.19	$104.19	$20.84	$20.84
17276	Destruction of skin lesions.	Y	Y		2.6253	$104.19	$104.19	$20.84	$20.84
17280	Destruction of skin lesions.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
17281	Destruction of skin lesions.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
17282	Destruction of skin lesions.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
17283	Destruction of skin lesions.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
17284	Destruction of skin lesions.	Y	Y		2.6253	$104.19	$104.19	$20.84	$20.84
17286	Destruction of skin lesions.	Y	Y		1.6062	$63.75	$63.75	$12.75	$12.75
17304	1 stage mohs, up to 5 spec.	Y	Y		3.4844	$138.29	$138.29	$27.66	$27.66

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
17305	2 stage mohs, up to 5 spec.	Y	Y		3.4844	$138.29	$138.29	$27.66	$27.66
17306	3 stage mohs, up to 5 spec.	Y	Y		3.4844	$138.29	$138.29	$27.66	$27.66
17307	Mohs addl stage up to 5 spec.	Y	Y		3.4844	$138.29	$138.29	$27.66	$27.66
17310	Mohs any stage > 5 spec each.	Y	Y	Y	1.5657	$62.14	$62.14	$12.43	$12.43
17340	Cryotherapy of skin.	Y	Y	Y	0.3096	$12.29	$12.29	$2.46	$2.46
17360	Skin peel therapy.	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
17380	Hair removal by electrolysis.	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
19000	Drainage of breast lesion.	Y	Y	Y	1.7129	$67.98	$67.98	$13.60	$13.60
19001	Drain breast lesion add-on.	Y	Y	Y	0.2210	$8.77	$8.77	$1.75	$1.75
19020	Incision of breast lesion.				17.4686	$693.30	$569.65	$138.66	$113.93
19100	Bx breast percut w/o image.				3.8051	$151.02	$192.61	$30.20	$38.52
19101	Biopsy of breast, open.				19.2250	$763.00	$604.50	$152.60	$120.90
19102	Bx breast percut w/image.				3.8051	$151.02	$192.61	$30.20	$38.52
19103	Bx breast percut w/device.				6.4482	$255.92	$326.40	$51.18	$65.28
19110	Nipple exploration.				19.2250	$763.00	$604.50	$152.60	$120.90
19112	Excise breast duct fistula.				19.2250	$763.00	$636.50	$152.60	$127.30
19120	Removal of breast lesion.				19.2250	$763.00	$636.50	$152.60	$127.30
19125	Excision, breast lesion.				19.2250	$763.00	$636.50	$152.60	$127.30
19126	Excision, addl breast lesion.				19.2250	$763.00	$636.50	$152.60	$127.30
19140	Removal of breast tissue.				19.2250	$763.00	$696.50	$152.60	$139.30
19160	Partial mastectomy.				19.2250	$763.00	$636.50	$152.60	$127.30
19162	P-mastectomy w/ln removal.				37.4843	$1,487.68	$1,241.34	$297.54	$248.27
19180	Removal of breast.				28.1505	$1,117.24	$873.62	$223.45	$174.72
19182	Removal of breast.				28.1505	$1,117.24	$873.62	$223.45	$174.72
19295	Place breast clip, percut.	Y			1.7625	$69.95	$69.95	$13.99	$13.99
19296	Place po breast cath for rad.				40.7495	$1,617.27	$1,478.13	$323.45	$295.63
19297	Place breast cath for rad.	Y			28.1505	$1,117.24	$1,117.24	$223.45	$223.45
19298	Place breast rad tube/caths.				-	$ -	$166.50	$ -	$33.30
19316	Suspension of breast.				28.1505	$1,117.24	$873.62	$223.45	$174.72
19318	Reduction of large breast.				37.4843	$1,487.68	$1,058.84	$297.54	$211.77
19324	Enlarge breast				37.4843	$1,487.68	$1,058.84	$297.54	$211.77
19325	Enlarge breast with implant.				48.7796	$1,935.97	$1,637.48	$387.19	$327.50
19328	Removal of breast implant.				28.1505	$1,117.24	$725.12	$223.45	$145.02
19330	Removal of implant material.				28.1505	$1,117.24	$725.12	$223.45	$145.02

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
19340	Immediate breast prosthesis.				40.7495	$1,617.27	$1,031.63	$323.45	$206.33
19342	Delayed breast prosthesis.				48.7796	$1,935.97	$1,222.98	$387.19	$244.60
19350	Breast reconstruction.				19.2250	$763.00	$696.50	$152.60	$139.30
19355	Correct inverted nipple(s).				28.1505	$1,117.24	$873.62	$223.45	$174.72
19357	Breast reconstruction.				48.7796	$1,935.97	$1,326.48	$387.19	$265.30
19366	Breast reconstruction.				28.1505	$1,117.24	$917.12	$223.45	$183.42
19370	Surgery of breast capsule.				28.1505	$1,117.24	$873.62	$223.45	$174.72
19371	Removal of breast capsule.				28.1505	$1,117.24	$873.62	$223.45	$174.72
19380	Revise breast reconstruction.				40.7495	$1,617.27	$1,167.13	$323.45	$233.43
19396	Design custom breast implant.	Y			28.1505	$1,117.24	$1,117.24	$223.45	$223.45
20000	Incision of abscess.	Y	Y		1.4821	$58.82	$58.82	$11.76	$11.76
20005	Incision of deep abscess.				20.8214	$826.36	$636.18	$165.27	$127.24
20103	Explore wound, extremity.	Y			4.1133	$163.25	$163.25	$32.65	$32.65
20150	Excise epiphyseal bar.	Y			41.2543	$1,637.30	$1,637.30	$327.46	$327.46
20200	Muscle biopsy				14.9563	$593.59	$519.79	$118.72	$103.96
20205	Deep muscle biopsy.				14.9563	$593.59	$551.79	$118.72	$110.36
20206	Needle biopsy, muscle.				3.8051	$151.02	$192.61	$30.20	$38.52
20220	Bone biopsy, trocar/needle.				4.0123	$159.24	$203.10	$31.85	$40.62
20225	Bone biopsy, trocar/needle.				6.5128	$258.48	$329.68	$51.70	$65.94
20240	Bone biopsy, excisional.				19.9760	$792.81	$619.40	$158.56	$123.88
20245	Bone biopsy, excisional.				19.9760	$792.81	$651.40	$158.56	$130.28
20250	Open bone biopsy.				20.8214	$826.36	$668.18	$165.27	$133.64
20251	Open bone biopsy.				20.8214	$826.36	$668.18	$165.27	$133.64
20500	Injection of sinus tract.	Y	Y	Y	1.5496	$61.50	$61.50	$12.30	$12.30
20520	Removal of foreign body.	Y	Y	Y	2.3536	$93.41	$93.41	$18.68	$18.68
20525	Removal of foreign body.				19.9760	$792.81	$651.40	$158.56	$130.28
20526	Ther injection, carp tunnel.	Y	Y	Y	0.7740	$30.72	$30.72	$6.14	$6.14
20550	Inject tendon/ligament/cyst.	Y	Y	Y	0.5718	$22.69	$22.69	$4.54	$4.54
20551	Inj tendon origin/insertion.	Y	Y	Y	0.5635	$22.37	$22.37	$4.47	$4.47
20552	Inj trigger point, 1/2 muscl.	Y	Y	Y	0.5564	$22.08	$22.08	$4.42	$4.42
20553	Inject trigger points, > 3.	Y	Y	Y	0.6242	$24.77	$24.77	$4.95	$4.95
20600	Drain/inject, joint/bursa.	Y	Y	Y	0.5622	$22.31	$22.31	$4.46	$4.46

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
20605	Drain/inject, joint/bursa.	Y	Y	Y	0.6427	$25.51	$25.51	$5.10	$5.10
20610	Drain/inject, joint/bursa.	Y	Y	Y	0.8759	$34.76	$34.76	$6.95	$6.95
20612	Aspirate/inj ganglion cyst.	Y	Y	Y	0.6035	$23.95	$23.95	$4.79	$4.79
20615	Treatment of bone cyst.	Y	Y		2.0863	$82.80	$82.80	$16.56	$16.56
20650	Insert and remove bone pin.				20.8214	$826.36	$668.18	$165.27	$133.64
20662	Application of pelvis brace.	Y	Y	Y	4.4737	$177.55	$177.55	$35.51	$35.51
20663	Application of thigh brace.	Y	Y	Y	4.2278	$167.79	$167.79	$33.56	$33.56
20665	Removal of fixation device.	Y			0.6211	$24.65	$24.65	$4.93	$4.93
20670	Removal of support implant.				14.9563	$593.59	$463.29	$118.72	$92.66
20680	Removal of support implant.				19.9760	$792.81	$651.40	$158.56	$130.28
20690	Apply bone fixation device.				25.0600	$994.58	$720.29	$198.92	$144.06
20692	Apply bone fixation device.				25.0600	$994.58	$752.29	$198.92	$150.46
20693	Adjust bone fixation device.				20.8214	$826.36	$668.18	$165.27	$133.64
20694	Remove bone fixation device.				20.8214	$826.36	$579.68	$165.27	$115.94
20822	Replantation digit, complete.	Y			25.8425	$1,025.64	$1,025.64	$205.13	$205.13
20900	Removal of bone for graft.				25.0600	$994.58	$752.29	$198.92	$150.46
20902	Removal of bone for graft.				25.0600	$994.58	$812.29	$198.92	$162.46
20910	Remove cartilage for graft.				21.2645	$843.95	$676.97	$168.79	$135.39
20912	Remove cartilage for graft.				21.2645	$843.95	$676.97	$168.79	$135.39
20920	Removal of fascia for graft.				13.3433	$529.57	$579.79	$105.91	$115.96
20922	Removal of fascia for graft.				21.2645	$843.95	$676.97	$168.79	$135.39
20924	Removal of tendon for graft.				25.0600	$994.58	$812.29	$198.92	$162.46
20926	Removal of tissue for graft.				13.3433	$529.57	$579.79	$105.91	$115.96
20972	Bone/skin graft, metatarsal.	Y			41.2239	$1,636.10	$1,636.10	$327.22	$327.22
20973	Bone/skin graft, great toe.	Y	Y	Y	16.9974	$674.60	$674.60	$134.92	$134.92
20975	Electrical bone stimulation.				0.6211	$24.65	$31.44	$4.93	$6.29
20982	Ablate, bone tumor(s) perq.	Y			25.0600	$994.58	$994.58	$198.92	$198.92
21010	Incision of jaw joint.				23.1564	$919.03	$682.52	$183.81	$136.50
21015	Resection of facial tumor.				16.4494	$652.85	$581.42	$130.57	$116.28
21025	Excision of bone, lower jaw.				37.7719	$1,499.09	$972.55	$299.82	$194.51
21026	Excision of facial bone(s).				37.7719	$1,499.09	$972.55	$299.82	$194.51
21029	Contour of face bone lesion.				37.7719	$1,499.09	$972.55	$299.82	$194.51

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
21030	Removal of face bone lesion.	Y	Y	Y	5.9541	$236.31	$236.31	$47.26	$47.26
21031	Remove exostosis, mandible.	Y	Y	Y	4.9253	$195.47	$195.47	$39.09	$39.09
21032	Remove exostosis, maxilla.	Y	Y	Y	5.0435	$200.17	$200.17	$40.03	$40.03
21034	Excise max/zygoma mlg tumor.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
21040	Excise mandible lesion.				23.1564	$919.03	$682.52	$183.81	$136.50
21044	Removal of jaw bone lesion.				37.7719	$1,499.09	$972.55	$299.82	$194.51
21046	Remove mandible cyst complex.				37.7719	$1,499.09	$972.55	$299.82	$194.51
21047	Excise lwr jaw cyst w/repair.				37.7719	$1,499.09	$972.55	$299.82	$194.51
21048	Remove maxilla cyst complex.	Y	Y	Y	10.3744	$411.74	$411.74	$82.35	$82.35
21050	Removal of jaw joint.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
21060	Remove jaw joint cartilage.				37.7719	$1,499.09	$972.55	$299.82	$194.51
21070	Remove coronoid process.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
21076	Prepare face/oral prosthesis.	Y	Y	Y	8.9380	$354.73	$354.73	$70.95	$70.95
21077	Prepare face/oral prosthesis.	Y	Y	Y	21.8677	$867.89	$867.89	$173.58	$173.58
21079	Prepare face/oral prosthesis.	Y	Y	Y	15.4101	$611.60	$611.60	$122.32	$122.32
21080	Prepare face/oral prosthesis.	Y	Y	Y	17.6321	$699.78	$699.78	$139.96	$139.96
21081	Prepare face/oral prosthesis.	Y	Y	Y	16.1148	$639.56	$639.56	$127.91	$127.91
21082	Prepare face/oral prosthesis.	Y	Y	Y	14.8249	$588.37	$588.37	$117.67	$117.67
21083	Prepare face/oral prosthesis.	Y	Y	Y	14.5513	$577.51	$577.51	$115.50	$115.50
21084	Prepare face/oral prosthesis.	Y	Y	Y	16.8041	$666.92	$666.92	$133.38	$133.38
21085	Prepare face/oral prosthesis.	Y	Y	Y	6.5587	$260.30	$260.30	$52.06	$52.06
21086	Prepare face/oral prosthesis.	Y	Y	Y	16.0903	$638.59	$638.59	$127.72	$127.72
21087	Prepare face/oral prosthesis.	Y	Y	Y	15.9673	$633.71	$633.71	$126.74	$126.74
21088	Prepare face/oral prosthesis.	Y	Y		37.7719	$1,499.09	$1,499.09	$299.82	$299.82
21100	Maxillofacial fixation.				37.7719	$1,499.09	$972.55	$299.82	$194.51

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

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21110	Interdental fixation.	Y	Y		7.7261	$306.63	$306.63	$61.33	$61.33
21120	Reconstruction of chin.				23.1564	$919.03	$957.02	$183.81	$191.40
21121	Reconstruction of chin.				23.1564	$919.03	$957.02	$183.81	$191.40
21122	Reconstruction of chin.				23.1564	$919.03	$957.02	$183.81	$191.40
21123	Reconstruction of chin.				23.1564	$919.03	$957.02	$183.81	$191.40
21125	Augmentation, lower jaw bone.				23.1564	$919.03	$957.02	$183.81	$191.40
21127	Augmentation, lower jaw bone.				37.7719	$1,499.09	$1,419.05	$299.82	$283.81
21137	Reduction of forehead.	Y			23.1564	$919.03	$919.03	$183.81	$183.81
21138	Reduction of forehead.	Y			37.7719	$1,499.09	$1,499.09	$299.82	$299.82
21139	Reduction of forehead.	Y			37.7719	$1,499.09	$1,499.09	$299.82	$299.82
21150	Reconstruct midface, lefort.	Y			37.7719	$1,499.09	$1,499.09	$299.82	$299.82
21181	Contour cranial bone lesion.				23.1564	$919.03	$957.02	$183.81	$191.40
21198	Reconstr lwr jaw segment.	Y			37.7719	$1,499.09	$1,499.09	$299.82	$299.82
21199	Reconstr lwr jaw w/advance.	Y			37.7719	$1,499.09	$1,499.09	$299.82	$299.82
21206	Reconstruct upper jaw bone.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
21208	Augmentation of facial bones.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
21209	Reduction of facial bones.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
21210	Face bone graft				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
21215	Lower jaw bone graft.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
21230	Rib cartilage graft.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
21235	Ear cartilage graft.				23.1564	$919.03	$957.02	$183.81	$191.40
21240	Reconstruction of jaw joint.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
21242	Reconstruction of jaw joint.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
21243	Reconstruction of jaw joint.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
21244	Reconstruction of lower jaw.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
21245	Reconstruction of jaw.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
21246	Reconstruction of jaw.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
21248	Reconstruction of jaw.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
21249	Reconstruction of jaw.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
21260	Revise eye sockets.	Y			37.7719	$1,499.09	$1,499.09	$299.82	$299.82
21267	Revise eye sockets.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
21270	Augmentation, cheek bone.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
21275	Revision, orbitofacial bones.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
21280	Revision of eyelid.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
21282	Revision of eyelid.				16.4494	$652.85	$684.92	$130.57	$136.98
21295	Revision of jaw muscle/bone.				7.7261	$306.63	$319.82	$61.33	$63.96
21296	Revision of jaw muscle/bone.				23.1564	$919.03	$626.02	$183.81	$125.20
21300	Treatment of skull fracture.				16.4494	$652.85	$549.42	$130.57	$109.88
21310	Treatment of nose fracture.				2.3768	$94.33	$120.31	$18.87	$24.06
21315	Treatment of nose fracture.				2.3768	$94.33	$120.31	$18.87	$24.06
21320	Treatment of nose fracture.				7.7261	$306.63	$376.32	$61.33	$75.26
21325	Treatment of nose fracture.				23.1564	$919.03	$774.52	$183.81	$154.90
21330	Treatment of nose fracture.				23.1564	$919.03	$818.02	$183.81	$163.60
21335	Treatment of nose fracture.				23.1564	$919.03	$957.02	$183.81	$191.40
21336	Treat nasal septal fracture.				37.5680	$1,491.00	$1,060.50	$298.20	$212.10
21337	Treat nasal septal fracture.				16.4494	$652.85	$549.42	$130.57	$109.88
21338	Treat nasoethmoid fracture.				23.1564	$919.03	$774.52	$183.81	$154.90
21339	Treat nasoethmoid fracture.				23.1564	$919.03	$818.02	$183.81	$163.60
21340	Treatment of nose fracture.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
21345	Treat nose/jaw fracture.				23.1564	$919.03	$957.02	$183.81	$191.40
21355	Treat cheek bone fracture.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
21356	Treat cheek bone fracture.	Y			23.1564	$919.03	$919.03	$183.81	$183.81
21390	Treat eye socket fracture.	Y			37.7719	$1,499.09	$1,499.09	$299.82	$299.82
21400	Treat eye socket fracture.				7.7261	$306.63	$376.32	$61.33	$75.26
21401	Treat eye socket fracture.				16.4494	$652.85	$581.42	$130.57	$116.28
21406	Treat eye socket fracture.	Y			37.7719	$1,499.09	$1,499.09	$299.82	$299.82
21407	Treat eye socket fracture.	Y			37.7719	$1,499.09	$1,499.09	$299.82	$299.82
21421	Treat mouth roof fracture.				23.1564	$919.03	$774.52	$183.81	$154.90
21440	Treat dental ridge fracture.	Y	Y	Y	7.6734	$304.54	$304.54	$60.91	$60.91
21445	Treat dental ridge fracture.				23.1564	$919.03	$774.52	$183.81	$154.90
21450	Treat lower jaw fracture.				2.3768	$94.33	$120.31	$18.87	$24.06
21451	Treat lower jaw fracture.				7.7261	$306.63	$391.09	$61.33	$78.22
21452	Treat lower jaw fracture.				16.4494	$652.85	$549.42	$130.57	$109.88
21453	Treat lower jaw fracture.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
21454	Treat lower jaw fracture.				23.1564	$919.03	$818.02	$183.81	$163.60
21461	Treat lower jaw fracture.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
21462	Treat lower jaw fracture.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
21465	Treat lower jaw fracture.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
21480	Reset dislocated jaw.				2.3768	$94.33	$120.31	$18.87	$24.06
21485	Reset dislocated jaw.				16.4494	$652.85	$549.42	$130.57	$109.88
21490	Repair dislocated jaw.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
21495	Treat hyoid bone fracture.	Y			16.4494	$652.85	$652.85	$130.57	$130.57
21497	Interdental wiring.				16.4494	$652.85	$549.42	$130.57	$109.88
21501	Drain neck/chest lesion.				17.4686	$693.30	$569.65	$138.66	$113.93
21502	Drain chest lesion.				20.8214	$826.36	$636.18	$165.27	$127.24
21550	Biopsy of neck/chest.	Y			6.5128	$258.48	$258.48	$51.70	$51.70
21555	Remove lesion, neck/chest.				19.9760	$792.81	$619.40	$158.56	$123.88
21556	Remove lesion, neck/chest.				19.9760	$792.81	$619.40	$158.56	$123.88
21557	Remove tumor, neck/chest.	Y			19.9760	$792.81	$792.81	$158.56	$158.56
21600	Partial removal of rib.				25.0600	$994.58	$720.29	$198.92	$144.06
21610	Partial removal of rib.				25.0600	$994.58	$720.29	$198.92	$144.06
21685	Hyoid myotomy & suspension.	Y			7.7261	$306.63	$306.63	$61.33	$61.33
21700	Revision of neck muscle.				20.8214	$826.36	$636.18	$165.27	$127.24
21720	Revision of neck muscle.				20.8214	$826.36	$668.18	$165.27	$133.64
21725	Revision of neck muscle.				1.4821	$58.82	$75.02	$11.76	$15.00
21800	Treatment of rib fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
21805	Treatment of rib fracture.				25.6702	$1,018.80	$732.40	$203.76	$146.48
21820	Treat sternum fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
21920	Biopsy soft tissue of back.	Y	Y	Y	3.3341	$132.32	$132.32	$26.46	$26.46
21925	Biopsy soft tissue of back.				19.9760	$792.81	$619.40	$158.56	$123.88
21930	Remove lesion, back or flank.				19.9760	$792.81	$619.40	$158.56	$123.88
21935	Remove tumor, back.				19.9760	$792.81	$651.40	$158.56	$130.28
22102	Remove part, lumbar vertebra.	Y			43.9030	$1,742.43	$1,742.43	$348.49	$348.49
22103	Remove extra spine segment.	Y			43.9030	$1,742.43	$1,742.43	$348.49	$348.49
22305	Treat spine process fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
22310	Treat spine fracture.				1.6914	$67.13	$85.62	$13.43	$17.12

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
22315	Treat spine fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
22505	Manipulation of spine.				14.5502	$577.47	$511.73	$115.49	$102.35
22520	Percut vertebroplasty thor.	Y			25.0600	$994.58	$994.58	$198.92	$198.92
22521	Percut vertebroplasty lumb.	Y			25.0600	$994.58	$994.58	$198.92	$198.92
22522	Percut vertebroplasty add'l.	Y			25.0600	$994.58	$994.58	$198.92	$198.92
22523	Percut kyphoplasty, thor.	Y			65.8846	$2,614.83	$2,614.83	$522.97	$522.97
22524	Percut kyphoplasty, lumbar.	Y			65.8846	$2,614.83	$2,614.83	$522.97	$522.97
22525	Percut kyphoplasty, add-on.	Y			65.8846	$2,614.83	$2,614.83	$522.97	$522.97
22900	Remove abdominal wall lesion.				19.9760	$792.81	$711.40	$158.56	$142.28
23000	Removal of calcium deposits.				14.9563	$593.59	$519.79	$118.72	$103.96
23020	Release shoulder joint.				41.2543	$1,637.30	$1,041.65	$327.46	$208.33
23030	Drain shoulder lesion.				17.4686	$693.30	$513.15	$138.66	$102.63
23031	Drain shoulder bursa.				17.4686	$693.30	$601.65	$138.66	$120.33
23035	Drain shoulder bone lesion.				20.8214	$826.36	$668.18	$165.27	$133.64
23040	Exploratory shoulder surgery.				25.0600	$994.58	$752.29	$198.92	$150.46
23044	Exploratory shoulder surgery.				25.0600	$994.58	$812.29	$198.92	$162.46
23065	Biopsy shoulder tissues.	Y	Y	Y	2.3504	$93.28	$93.28	$18.66	$18.66
23066	Biopsy shoulder tissues.				19.9760	$792.81	$619.40	$158.56	$123.88
23075	Removal of shoulder lesion.				14.9563	$593.59	$519.79	$118.72	$103.96
23076	Removal of shoulder lesion.				19.9760	$792.81	$619.40	$158.56	$123.88
23077	Remove tumor of shoulder.				19.9760	$792.81	$651.40	$158.56	$130.28
23100	Biopsy of shoulder joint.				20.8214	$826.36	$636.18	$165.27	$127.24
23101	Shoulder joint surgery.				25.0600	$994.58	$994.79	$198.92	$198.96
23105	Remove shoulder joint lining.				25.0600	$994.58	$812.29	$198.92	$162.46
23106	Incision of collarbone joint.				25.0600	$994.58	$812.29	$198.92	$162.46
23107	Explore treat shoulder joint.				25.0600	$994.58	$812.29	$198.92	$162.46
23120	Partial removal, collar bone.				41.2543	$1,637.30	$1,177.15	$327.46	$235.43
23125	Removal of collar bone.				41.2543	$1,637.30	$1,177.15	$327.46	$235.43

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
23130	Remove shoulder bone, part.				41.2543	$1,637.30	$1,177.15	$327.46	$235.43
23140	Removal of bone lesion.				20.8214	$826.36	$728.18	$165.27	$145.64
23145	Removal of bone lesion.				25.0600	$994.58	$855.79	$198.92	$171.16
23146	Removal of bone lesion.				25.0600	$994.58	$855.79	$198.92	$171.16
23150	Removal of humerus lesion.				25.0600	$994.58	$812.29	$198.92	$162.46
23155	Removal of humerus lesion.				25.0600	$994.58	$855.79	$198.92	$171.16
23156	Removal of humerus lesion.				25.0600	$994.58	$855.79	$198.92	$171.16
23170	Remove collar bone lesion.				25.0600	$994.58	$720.29	$198.92	$144.06
23172	Remove shoulder blade lesion.				25.0600	$994.58	$720.29	$198.92	$144.06
23174	Remove humerus lesion.				25.0600	$994.58	$720.29	$198.92	$144.06
23180	Remove collar bone lesion.				25.0600	$994.58	$812.29	$198.92	$162.46
23182	Remove shoulder blade lesion.				25.0600	$994.58	$812.29	$198.92	$162.46
23184	Remove humerus lesion.				25.0600	$994.58	$812.29	$198.92	$162.46
23190	Partial removal of scapula.				25.0600	$994.58	$812.29	$198.92	$162.46
23195	Removal of head of humerus.				25.0600	$994.58	$855.79	$198.92	$171.16
23330	Remove shoulder foreign body.				6.5128	$258.48	$295.74	$51.70	$59.15
23331	Remove shoulder foreign body.				19.9760	$792.81	$562.90	$158.56	$112.58
23395	Muscle transfer,shoulder/arm.				41.2543	$1,637.30	$1,177.15	$327.46	$235.43
23397	Muscle transfers				65.8846	$2,614.83	$1,804.92	$522.97	$360.98
23400	Fixation of shoulder blade.				25.0600	$994.58	$994.79	$198.92	$198.96
23405	Incision of tendon & muscle.				25.0600	$994.58	$720.29	$198.92	$144.06
23406	Incise tendon(s) & muscle(s).				25.0600	$994.58	$720.29	$198.92	$144.06
23410	Repair rotator cuff, acute.				41.2543	$1,637.30	$1,177.15	$327.46	$235.43
23412	Repair rotator cuff, chronic.				41.2543	$1,637.30	$1,316.15	$327.46	$263.23
23415	Release of shoulder ligament.				41.2543	$1,637.30	$1,177.15	$327.46	$235.43
23420	Repair of shoulder.				41.2543	$1,637.30	$1,316.15	$327.46	$263.23
23430	Repair biceps tendon.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
23440	Remove/transplant tendon.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
23450	Repair shoulder capsule.				65.8846	$2,614.83	$1,665.92	$522.97	$333.18
23455	Repair shoulder capsule.				65.8846	$2,614.83	$1,804.92	$522.97	$360.98

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
23460	Repair shoulder capsule.				65.8846	$2,614.83	$1,665.92	$522.97	$333.18
23462	Repair shoulder capsule.				41.2543	$1,637.30	$1,316.15	$327.46	$263.23
23465	Repair shoulder capsule.				65.8846	$2,614.83	$1,665.92	$522.97	$333.18
23466	Repair shoulder capsule.				41.2543	$1,637.30	$1,316.15	$327.46	$263.23
23480	Revision of collar bone.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
23485	Revision of collar bone.				65.8846	$2,614.83	$1,804.92	$522.97	$360.98
23490	Reinforce clavicle.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
23491	Reinforce shoulder bones.				65.8846	$2,614.83	$1,562.42	$522.97	$312.48
23500	Treat clavicle fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
23505	Treat clavicle fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
23515	Treat clavicle fracture.				56.4195	$2,239.18	$1,374.59	$447.84	$274.92
23520	Treat clavicle dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
23525	Treat clavicle dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
23530	Treat clavicle dislocation.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
23532	Treat clavicle dislocation.				25.6702	$1,018.80	$824.40	$203.76	$164.88
23540	Treat clavicle dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
23545	Treat clavicle dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
23550	Treat clavicle dislocation.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
23552	Treat clavicle dislocation.				37.5680	$1,491.00	$1,060.50	$298.20	$212.10
23570	Treat shoulder blade fx.				1.6914	$67.13	$85.62	$13.43	$17.12
23575	Treat shoulder blade fx.				1.6914	$67.13	$85.62	$13.43	$17.12
23585	Treat scapula fracture.				56.4195	$2,239.18	$1,374.59	$447.84	$274.92
23600	Treat humerus fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
23605	Treat humerus fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
23615	Treat humerus fracture.				56.4195	$2,239.18	$1,434.59	$447.84	$286.92
23616	Treat humerus fracture.				56.4195	$2,239.18	$1,434.59	$447.84	$286.92
23620	Treat humerus fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
23625	Treat humerus fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
23630	Treat humerus fracture.				56.4195	$2,239.18	$1,478.09	$447.84	$295.62
23650	Treat shoulder dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
23655	Treat shoulder dislocation.				14.5502	$577.47	$455.23	$115.49	$91.05
23660	Treat shoulder dislocation.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
23665	Treat dislocation/fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
23670	Treat dislocation/fracture.				56.4195	$2,239.18	$1,374.59	$447.84	$274.92

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
23675	Treat dislocation/fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
23680	Treat dislocation/fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
23700	Fixation of shoulder.				14.5502	$577.47	$455.23	$115.49	$91.05
23800	Fusion of shoulder joint.				65.8846	$2,614.83	$1,622.42	$522.97	$324.48
23802	Fusion of shoulder joint.				41.2543	$1,637.30	$1,316.15	$327.46	$263.23
23921	Amputation follow-up surgery.				5.0931	$202.14	$257.81	$40.43	$51.56
23930	Drainage of arm lesion.				17.4686	$693.30	$513.15	$138.66	$102.63
23931	Drainage of arm bursa.				17.4686	$693.30	$569.65	$138.66	$113.93
23935	Drain arm/elbow bone lesion.				20.8214	$826.36	$636.18	$165.27	$127.24
24000	Exploratory elbow surgery.				25.0600	$994.58	$812.29	$198.92	$162.46
24006	Release elbow joint.				25.0600	$994.58	$812.29	$198.92	$162.46
24065	Biopsy arm/elbow soft tissue.	Y	Y	Y	3.1861	$126.45	$126.45	$25.29	$25.29
24066	Biopsy arm/elbow soft tissue.				14.9563	$593.59	$519.79	$118.72	$103.96
24075	Remove arm/elbow lesion.				14.9563	$593.59	$519.79	$118.72	$103.96
24076	Remove arm/elbow lesion.				19.9760	$792.81	$619.40	$158.56	$123.88
24077	Remove tumor of arm/elbow.				19.9760	$792.81	$651.40	$158.56	$130.28
24100	Biopsy elbow joint lining.				20.8214	$826.36	$579.68	$165.27	$115.94
24101	Explore/treat elbow joint.				25.0600	$994.58	$812.29	$198.92	$162.46
24102	Remove elbow joint lining.				25.0600	$994.58	$812.29	$198.92	$162.46
24105	Removal of elbow bursa.				20.8214	$826.36	$668.18	$165.27	$133.64
24110	Remove humerus lesion.				20.8214	$826.36	$636.18	$165.27	$127.24
24115	Remove/graft bone lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
24116	Remove/graft bone lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
24120	Remove elbow lesion.				20.8214	$826.36	$668.18	$165.27	$133.64
24125	Remove/graft bone lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
24126	Remove/graft bone lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
24130	Removal of head of radius.				25.0600	$994.58	$752.29	$198.92	$150.46
24134	Removal of arm bone lesion.				25.0600	$994.58	$720.29	$198.92	$144.06
24136	Remove radius bone lesion.				25.0600	$994.58	$720.29	$198.92	$144.06
24138	Remove elbow bone lesion.				25.0600	$994.58	$720.29	$198.92	$144.06
24140	Partial removal of arm bone.				25.0600	$994.58	$752.29	$198.92	$150.46
24145	Partial removal of radius.				25.0600	$994.58	$752.29	$198.92	$150.46

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
24147	Partial removal of elbow.				25.0600	$994.58	$720.29	$198.92	$144.06
24149	Radical resection of elbow.	Y			25.0600	$994.58	$994.58	$198.92	$198.92
24152	Extensive radius surgery.	Y			41.2543	$1,637.30	$1,637.30	$327.46	$327.46
24153	Extensive radius surgery.	Y			65.8846	$2,614.83	$2,614.83	$522.97	$522.97
24155	Removal of elbow joint.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
24160	Remove elbow joint implant.				25.0600	$994.58	$720.29	$198.92	$144.06
24164	Remove radius head implant.				25.0600	$994.58	$752.29	$198.92	$150.46
24200	Removal of arm foreign body.	Y	Y	Y	2.6370	$104.66	$104.66	$20.93	$20.93
24201	Removal of arm foreign body.				14.9563	$593.59	$519.79	$118.72	$103.96
24300	Manipulate elbow w/ anesth.	Y			14.5502	$577.47	$577.47	$115.49	$115.49
24301	Muscle/tendon transfer.				25.0600	$994.58	$812.29	$198.92	$162.46
24305	Arm tendon lengthening.				25.0600	$994.58	$812.29	$198.92	$162.46
24310	Revision of arm tendon.				20.8214	$826.36	$668.18	$165.27	$133.64
24320	Repair of arm tendon.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
24330	Revision of arm muscles.				65.8846	$2,614.83	$1,562.42	$522.97	$312.48
24331	Revision of arm muscles.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
24332	Tenolysis, triceps.	Y			20.8214	$826.36	$826.36	$165.27	$165.27
24340	Repair of biceps tendon.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
24341	Repair arm tendon/muscle.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
24342	Repair of ruptured tendon.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
24343	Repr elbow lat ligmnt w/tiss.	Y			25.0600	$994.58	$994.58	$198.92	$198.92
24344	Reconstruct elbow lat ligmnt.	Y			65.8846	$2,614.83	$2,614.83	$522.97	$522.97
24345	Repr elbw med ligmnt w/tissu.				25.0600	$994.58	$720.29	$198.92	$144.06
24346	Reconstruct elbow med ligmnt.	Y			41.2543	$1,637.30	$1,637.30	$327.46	$327.46
24350	Repair of tennis elbow.				25.0600	$994.58	$752.29	$198.92	$150.46
24351	Repair of tennis elbow.				25.0600	$994.58	$752.29	$198.92	$150.46
24352	Repair of tennis elbow.				25.0600	$994.58	$752.29	$198.92	$150.46
24354	Repair of tennis elbow.				25.0600	$994.58	$752.29	$198.92	$150.46
24356	Revision of tennis elbow.				25.0600	$994.58	$752.29	$198.92	$150.46
24360	Reconstruct elbow joint.				32.7543	$1,299.96	$1,008.48	$259.99	$201.70
24361	Reconstruct elbow joint.				105.1666	$4,173.86	$2,445.43	$834.77	$489.09
24362	Reconstruct elbow joint.				47.1644	$1,871.86	$1,294.43	$374.37	$258.89

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
24363	Replace elbow joint.				105.1666	$4,173.86	$2,584.43	$834.77	$516.89
24365	Reconstruct head of radius.				32.7543	$1,299.96	$1,008.48	$259.99	$201.70
24366	Reconstruct head of radius.				105.1666	$4,173.86	$2,445.43	$834.77	$489.09
24400	Revision of humerus.				25.0600	$994.58	$812.29	$198.92	$162.46
24410	Revision of humerus.				25.0600	$994.58	$812.29	$198.92	$162.46
24420	Revision of humerus.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
24430	Repair of humerus.				65.8846	$2,614.83	$1,562.42	$522.97	$312.48
24435	Repair humerus with graft.				65.8846	$2,614.83	$1,622.42	$522.97	$324.48
24470	Revision of elbow joint.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
24495	Decompression of forearm.				25.0600	$994.58	$720.29	$198.92	$144.06
24498	Reinforce humerus.				65.8846	$2,614.83	$1,562.42	$522.97	$312.48
24500	Treat humerus fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
24505	Treat humerus fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
24515	Treat humerus fracture.				56.4195	$2,239.18	$1,434.59	$447.84	$286.92
24516	Treat humerus fracture.				56.4195	$2,239.18	$1,434.59	$447.84	$286.92
24530	Treat humerus fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
24535	Treat humerus fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
24538	Treat humerus fracture.				25.6702	$1,018.80	$732.40	$203.76	$146.48
24545	Treat humerus fracture.				56.4195	$2,239.18	$1,434.59	$447.84	$286.92
24546	Treat humerus fracture.				56.4195	$2,239.18	$1,478.09	$447.84	$295.62
24560	Treat humerus fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
24565	Treat humerus fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
24566	Treat humerus fracture.				25.6702	$1,018.80	$732.40	$203.76	$146.48
24575	Treat humerus fracture.				56.4195	$2,239.18	$1,374.59	$447.84	$274.92
24576	Treat humerus fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
24577	Treat humerus fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
24579	Treat humerus fracture.				56.4195	$2,239.18	$1,374.59	$447.84	$274.92
24582	Treat humerus fracture.				25.6702	$1,018.80	$732.40	$203.76	$146.48
24586	Treat elbow fracture.				56.4195	$2,239.18	$1,434.59	$447.84	$286.92
24587	Treat elbow fracture.				56.4195	$2,239.18	$1,478.09	$447.84	$295.62
24600	Treat elbow dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
24605	Treat elbow dislocation.				14.5502	$577.47	$511.73	$115.49	$102.35
24615	Treat elbow dislocation.				56.4195	$2,239.18	$1,374.59	$447.84	$274.92

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
24620	Treat elbow fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
24635	Treat elbow fracture.				56.4195	$2,239.18	$1,374.59	$447.84	$274.92
24640	Treat elbow dislocation.	Y			1.6914	$67.13	$67.13	$13.43	$13.43
24650	Treat radius fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
24655	Treat radius fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
24665	Treat radius fracture.				37.5680	$1,491.00	$1,060.50	$298.20	$212.10
24666	Treat radius fracture.				56.4195	$2,239.18	$1,434.59	$447.84	$286.92
24670	Treat ulnar fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
24675	Treat ulnar fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
24685	Treat ulnar fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
24800	Fusion of elbow joint.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
24802	Fusion/graft of elbow joint.				41.2543	$1,637.30	$1,177.15	$327.46	$235.43
24925	Amputation follow-up surgery.				20.8214	$826.36	$668.18	$165.27	$133.64
25000	Incision of tendon sheath.				20.8214	$826.36	$668.18	$165.27	$133.64
25001	Incise flexor carpi radialis.	Y			20.8214	$826.36	$826.36	$165.27	$165.27
25020	Decompress forearm 1 space.				20.8214	$826.36	$668.18	$165.27	$133.64
25023	Decompress forearm 1 space.				25.0600	$994.58	$752.29	$198.92	$150.46
25024	Decompress forearm 2 spaces.				25.0600	$994.58	$752.29	$198.92	$150.46
25025	Decompress forearm 2 spaces.				25.0600	$994.58	$752.29	$198.92	$150.46
25028	Drainage of forearm lesion.				20.8214	$826.36	$579.68	$165.27	$115.94
25031	Drainage of forearm bursa.				20.8214	$826.36	$636.18	$165.27	$127.24
25035	Treat forearm bone lesion.				20.8214	$826.36	$636.18	$165.27	$127.24
25040	Explore/treat wrist joint.				25.0600	$994.58	$855.79	$198.92	$171.16
25065	Biopsy forearm soft tissues.	Y	Y	Y	3.2509	$129.02	$129.02	$25.80	$25.80
25066	Biopsy forearm soft tissues.				19.9760	$792.81	$619.40	$158.56	$123.88
25075	Removal forearm lesion subcu.				14.9563	$593.59	$519.79	$118.72	$103.96
25076	Removal forearm lesion deep.				19.9760	$792.81	$651.40	$158.56	$130.28
25077	Remove tumor, forearm/wrist.				19.9760	$792.81	$651.40	$158.56	$130.28
25085	Incision of wrist capsule.				20.8214	$826.36	$668.18	$165.27	$133.64
25100	Biopsy of wrist joint.				20.8214	$826.36	$636.18	$165.27	$127.24

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
25101	Explore/treat wrist joint.				25.0600	$994.58	$752.29	$198.92	$150.46
25105	Remove wrist joint lining.				25.0600	$994.58	$812.29	$198.92	$162.46
25107	Remove wrist joint cartilage.				25.0600	$994.58	$752.29	$198.92	$150.46
25110	Remove wrist tendon lesion.				20.8214	$826.36	$668.18	$165.27	$133.64
25111	Remove wrist tendon lesion.				16.0343	$636.37	$573.19	$127.27	$114.64
25112	Reremove wrist tendon lesion.				16.0343	$636.37	$633.19	$127.27	$126.64
25115	Remove wrist/forearm lesion.				20.8214	$826.36	$728.18	$165.27	$145.64
25116	Remove wrist/forearm lesion.				20.8214	$826.36	$728.18	$165.27	$145.64
25118	Excise wrist tendon sheath.				25.0600	$994.58	$720.29	$198.92	$144.06
25119	Partial removal of ulna.				25.0600	$994.58	$752.29	$198.92	$150.46
25120	Removal of forearm lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
25125	Remove/graft forearm lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
25126	Remove/graft forearm lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
25130	Removal of wrist lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
25135	Remove & graft wrist lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
25136	Remove & graft wrist lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
25145	Remove forearm bone lesion.				25.0600	$994.58	$720.29	$198.92	$144.06
25150	Partial removal of ulna.				25.0600	$994.58	$720.29	$198.92	$144.06
25151	Partial removal of radius.				25.0600	$994.58	$720.29	$198.92	$144.06
25210	Removal of wrist bone.				25.8425	$1,025.64	$767.82	$205.13	$153.56
25215	Removal of wrist bones.				25.8425	$1,025.64	$827.82	$205.13	$165.56
25230	Partial removal of radius.				25.0600	$994.58	$812.29	$198.92	$162.46
25240	Partial removal of ulna.				25.0600	$994.58	$812.29	$198.92	$162.46
25248	Remove forearm foreign body.				20.8214	$826.36	$636.18	$165.27	$127.24
25250	Removal of wrist prosthesis.				25.0600	$994.58	$663.79	$198.92	$132.76
25251	Removal of wrist prosthesis.				25.0600	$994.58	$663.79	$198.92	$132.76
25259	Manipulate wrist w/anesthes.	Y			1.6914	$67.13	$67.13	$13.43	$13.43
25260	Repair forearm tendon/muscle.				25.0600	$994.58	$812.29	$198.92	$162.46
25263	Repair forearm tendon/muscle.				25.0600	$994.58	$720.29	$198.92	$144.06
25265	Repair forearm tendon/muscle.				25.0600	$994.58	$752.29	$198.92	$150.46

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
25270	Repair forearm tendon/muscle.				25.0600	$994.58	$812.29	$198.92	$162.46
25272	Repair forearm tendon/muscle.				25.0600	$994.58	$752.29	$198.92	$150.46
25274	Repair forearm tendon/muscle.				25.0600	$994.58	$812.29	$198.92	$162.46
25275	Repair forearm tendon sheath.				25.0600	$994.58	$812.29	$198.92	$162.46
25280	Revise wrist/forearm tendon.				25.0600	$994.58	$812.29	$198.92	$162.46
25290	Incise wrist/forearm tendon.				25.0600	$994.58	$752.29	$198.92	$150.46
25295	Release wrist/forearm tendon.				20.8214	$826.36	$668.18	$165.27	$133.64
25300	Fusion of tendons at wrist.				25.0600	$994.58	$752.29	$198.92	$150.46
25301	Fusion of tendons at wrist.				25.0600	$994.58	$752.29	$198.92	$150.46
25310	Transplant forearm tendon.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
25312	Transplant forearm tendon.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
25315	Revise palsy hand tendon(s).				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
25316	Revise palsy hand tendon(s).				65.8846	$2,614.83	$1,562.42	$522.97	$312.48
25320	Repair/revise wrist joint.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
25332	Revise wrist joint.				32.7543	$1,299.96	$1,008.48	$259.99	$201.70
25335	Realignment of hand.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
25337	Reconstruct ulna/radioulnar.				41.2543	$1,637.30	$1,177.15	$327.46	$235.43
25350	Revision of radius.				65.8846	$2,614.83	$1,562.42	$522.97	$312.48
25355	Revision of radius.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
25360	Revision of ulna				25.0600	$994.58	$752.29	$198.92	$150.46
25365	Revise radius & ulna.				25.0600	$994.58	$752.29	$198.92	$150.46
25370	Revise radius or ulna.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
25375	Revise radius & ulna.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
25390	Shorten radius or ulna.				25.0600	$994.58	$752.29	$198.92	$150.46
25391	Lengthen radius or ulna.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
25392	Shorten radius & ulna.				25.0600	$994.58	$752.29	$198.92	$150.46
25393	Lengthen radius & ulna.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
25394	Repair carpal bone, shorten.	Y			16.0343	$636.37	$636.37	$127.27	$127.27
25400	Repair radius or ulna.				25.0600	$994.58	$752.29	$198.92	$150.46
25405	Repair/graft radius or ulna.				25.0600	$994.58	$812.29	$198.92	$162.46

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
25415	Repair radius & ulna.				25.0600	$994.58	$752.29	$198.92	$150.46
25420	Repair/graft radius & ulna.				65.8846	$2,614.83	$1,622.42	$522.97	$324.48
25425	Repair/graft radius or ulna.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
25426	Repair/graft radius & ulna.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
25430	Vasc graft into carpal bone.	Y			25.8425	$1,025.64	$1,025.64	$205.13	$205.13
25431	Repair nonunion carpal bone.	Y			25.8425	$1,025.64	$1,025.64	$205.13	$205.13
25440	Repair/graft wrist bone.				65.8846	$2,614.83	$1,622.42	$522.97	$324.48
25441	Reconstruct wrist joint.				105.1666	$4,173.86	$2,445.43	$834.77	$489.09
25442	Reconstruct wrist joint.				105.1666	$4,173.86	$2,445.43	$834.77	$489.09
25443	Reconstruct wrist joint.				47.1644	$1,871.86	$1,294.43	$374.37	$258.89
25444	Reconstruct wrist joint.				47.1644	$1,871.86	$1,294.43	$374.37	$258.89
25445	Reconstruct wrist joint.				47.1644	$1,871.86	$1,294.43	$374.37	$258.89
25446	Wrist replacement.				105.1666	$4,173.86	$2,584.43	$834.77	$516.89
25447	Repair wrist joint(s).				32.7543	$1,299.96	$1,008.48	$259.99	$201.70
25449	Remove wrist joint implant.				32.7543	$1,299.96	$1,008.48	$259.99	$201.70
25450	Revision of wrist joint.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
25455	Revision of wrist joint.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
25490	Reinforce radius				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
25491	Reinforce ulna				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
25492	Reinforce radius and ulna.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
25500	Treat fracture of radius.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
25505	Treat fracture of radius.				1.6914	$67.13	$85.62	$13.43	$17.12
25515	Treat fracture of radius.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
25520	Treat fracture of radius.				1.6914	$67.13	$85.62	$13.43	$17.12
25525	Treat fracture of radius.				37.5680	$1,491.00	$1,060.50	$298.20	$212.10
25526	Treat fracture of radius.				37.5680	$1,491.00	$1,104.00	$298.20	$220.80
25530	Treat fracture of ulna.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
25535	Treat fracture of ulna.				1.6914	$67.13	$85.62	$13.43	$17.12
25545	Treat fracture of ulna.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
25560	Treat fracture radius & ulna.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
25565	Treat fracture radius & ulna.				1.6914	$67.13	$85.62	$13.43	$17.12
25574	Treat fracture radius & ulna.				56.4195	$2,239.18	$1,374.59	$447.84	$274.92
25575	Treat fracture radius/ulna.				56.4195	$2,239.18	$1,374.59	$447.84	$274.92
25600	Treat fracture radius/ulna.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
25605	Treat fracture radius/ulna.				1.6914	$67.13	$85.62	$13.43	$17.12

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
25611	Treat fracture radius/ulna.				25.6702	$1,018.80	$764.40	$203.76	$152.88
25620	Treat fracture radius/ulna.				56.4195	$2,239.18	$1,478.09	$447.84	$295.62
25622	Treat wrist bone fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
25624	Treat wrist bone fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
25628	Treat wrist bone fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
25630	Treat wrist bone fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
25635	Treat wrist bone fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
25645	Treat wrist bone fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
25650	Treat wrist bone fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
25651	Pin ulnar styloid fracture.	Y			25.6702	$1,018.80	$1,018.80	$203.76	$203.76
25652	Treat fracture ulnar styloid.	Y			37.5680	$1,491.00	$1,491.00	$298.20	$298.20
25660	Treat wrist dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
25670	Treat wrist dislocation.				25.6702	$1,018.80	$764.40	$203.76	$152.88
25671	Pin radioulnar dislocation.				25.6702	$1,018.80	$675.90	$203.76	$135.18
25675	Treat wrist dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
25676	Treat wrist dislocation.				25.6702	$1,018.80	$732.40	$203.76	$146.48
25680	Treat wrist fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
25685	Treat wrist fracture.				25.6702	$1,018.80	$764.40	$203.76	$152.88
25690	Treat wrist dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
25695	Treat wrist dislocation.				25.6702	$1,018.80	$732.40	$203.76	$146.48
25800	Fusion of wrist joint.				65.8846	$2,614.83	$1,622.42	$522.97	$324.48
25805	Fusion/graft of wrist joint.				41.2543	$1,637.30	$1,177.15	$327.46	$235.43
25810	Fusion/graft of wrist joint.				65.8846	$2,614.83	$1,665.92	$522.97	$333.18
25820	Fusion of hand bones.				16.0343	$636.37	$633.19	$127.27	$126.64
25825	Fuse hand bones with graft.				25.8425	$1,025.64	$871.32	$205.13	$174.26
25830	Fusion, radioulnar jnt/ulna.				65.8846	$2,614.83	$1,665.92	$522.97	$333.18
25907	Amputation follow-up surgery.				20.8214	$826.36	$668.18	$165.27	$133.64
25922	Amputate hand at wrist.				20.8214	$826.36	$668.18	$165.27	$133.64
25929	Amputation follow-up surgery.				13.3433	$529.57	$519.79	$105.91	$103.96
26010	Drainage of finger abscess.	Y	Y		1.4821	$58.82	$58.82	$11.76	$11.76
26011	Drainage of finger abscess.				10.9184	$433.33	$383.17	$86.67	$76.63
26020	Drain hand tendon sheath.				16.0343	$636.37	$541.19	$127.27	$108.24

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
26025	Drainage of palm bursa.				16.0343	$636.37	$484.69	$127.27	$96.94
26030	Drainage of palm bursa(s).				16.0343	$636.37	$541.19	$127.27	$108.24
26034	Treat hand bone lesion.				16.0343	$636.37	$541.19	$127.27	$108.24
26035	Decompress fingers/hand.	Y			16.0343	$636.37	$636.37	$127.27	$127.27
26040	Release palm contracture.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26045	Release palm contracture.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26055	Incise finger tendon sheath.				16.0343	$636.37	$541.19	$127.27	$108.24
26060	Incision of finger tendon.				16.0343	$636.37	$541.19	$127.27	$108.24
26070	Explore/treat hand joint.				16.0343	$636.37	$541.19	$127.27	$108.24
26075	Explore/treat finger joint.				16.0343	$636.37	$633.19	$127.27	$126.64
26080	Explore/treat finger joint.				16.0343	$636.37	$633.19	$127.27	$126.64
26100	Biopsy hand joint lining.				16.0343	$636.37	$541.19	$127.27	$108.24
26105	Biopsy finger joint lining.				16.0343	$636.37	$484.69	$127.27	$96.94
26110	Biopsy finger joint lining.				16.0343	$636.37	$484.69	$127.27	$96.94
26115	Removal hand lesion subcut.				19.9760	$792.81	$619.40	$158.56	$123.88
26116	Removal hand lesion, deep.				19.9760	$792.81	$619.40	$158.56	$123.88
26117	Remove tumor, hand/finger.				19.9760	$792.81	$651.40	$158.56	$130.28
26121	Release palm contracture.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26123	Release palm contracture.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26125	Release palm contracture.				16.0343	$636.37	$633.19	$127.27	$126.64
26130	Remove wrist joint lining.				16.0343	$636.37	$573.19	$127.27	$114.64
26135	Revise finger joint, each.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26140	Revise finger joint, each.				16.0343	$636.37	$541.19	$127.27	$108.24
26145	Tendon excision, palm/finger.				16.0343	$636.37	$573.19	$127.27	$114.64
26160	Remove tendon sheath lesion.				16.0343	$636.37	$573.19	$127.27	$114.64
26170	Removal of palm tendon, each.				16.0343	$636.37	$573.19	$127.27	$114.64
26180	Removal of finger tendon.				16.0343	$636.37	$573.19	$127.27	$114.64
26185	Remove finger bone.				16.0343	$636.37	$633.19	$127.27	$126.64
26200	Remove hand bone lesion.				16.0343	$636.37	$541.19	$127.27	$108.24
26205	Remove/graft bone lesion.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26210	Removal of finger lesion.				16.0343	$636.37	$541.19	$127.27	$108.24
26215	Remove/graft finger lesion.				16.0343	$636.37	$573.19	$127.27	$114.64
26230	Partial removal of hand bone.				16.0343	$636.37	$811.65	$127.27	$162.33

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
26235	Partial removal, finger bone.				16.0343	$636.37	$573.19	$127.27	$114.64
26236	Partial removal, finger bone.				16.0343	$636.37	$573.19	$127.27	$114.64
26250	Extensive hand surgery.				16.0343	$636.37	$573.19	$127.27	$114.64
26255	Extensive hand surgery.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26260	Extensive finger surgery.				16.0343	$636.37	$573.19	$127.27	$114.64
26261	Extensive finger surgery.				16.0343	$636.37	$573.19	$127.27	$114.64
26262	Partial removal of finger.				16.0343	$636.37	$541.19	$127.27	$108.24
26320	Removal of implant from hand.				14.9563	$593.59	$519.79	$118.72	$103.96
26340	Manipulate finger w/anesth.	Y			1.6914	$67.13	$67.13	$13.43	$13.43
26350	Repair finger/hand tendon.				25.8425	$1,025.64	$679.32	$205.13	$135.86
26352	Repair/graft hand tendon.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26356	Repair finger/hand tendon.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26357	Repair finger/hand tendon.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26358	Repair/graft hand tendon.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26370	Repair finger/hand tendon.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26372	Repair/graft hand tendon.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26373	Repair finger/hand tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26390	Revise hand/finger tendon.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26392	Repair/graft hand tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26410	Repair hand tendon.				16.0343	$636.37	$573.19	$127.27	$114.64
26412	Repair/graft hand tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26415	Excision, hand/finger tendon.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26416	Graft hand or finger tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26418	Repair finger tendon.				16.0343	$636.37	$633.19	$127.27	$126.64
26420	Repair/graft finger tendon.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26426	Repair finger/hand tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26428	Repair/graft finger tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26432	Repair finger tendon.				16.0343	$636.37	$573.19	$127.27	$114.64
26433	Repair finger tendon.				16.0343	$636.37	$573.19	$127.27	$114.64
26434	Repair/graft finger tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26437	Realignment of tendons.				16.0343	$636.37	$573.19	$127.27	$114.64
26440	Release palm/finger tendon.				16.0343	$636.37	$573.19	$127.27	$114.64
26442	Release palm & finger tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
26445	Release hand/finger tendon.				16.0343	$636.37	$573.19	$127.27	$114.64
26449	Release forearm/hand tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26450	Incision of palm tendon.				16.0343	$636.37	$573.19	$127.27	$114.64
26455	Incision of finger tendon.				16.0343	$636.37	$573.19	$127.27	$114.64
26460	Incise hand/finger tendon.				16.0343	$636.37	$573.19	$127.27	$114.64
26471	Fusion of finger tendons.				16.0343	$636.37	$541.19	$127.27	$108.24
26474	Fusion of finger tendons.				16.0343	$636.37	$541.19	$127.27	$108.24
26476	Tendon lengthening.				16.0343	$636.37	$484.69	$127.27	$96.94
26477	Tendon shortening.				16.0343	$636.37	$484.69	$127.27	$96.94
26478	Lengthening of hand tendon.				16.0343	$636.37	$484.69	$127.27	$96.94
26479	Shortening of hand tendon.				16.0343	$636.37	$484.69	$127.27	$96.94
26480	Transplant hand tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26483	Transplant/graft hand tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26485	Transplant palm tendon.				25.8425	$1,025.64	$735.82	$205.13	$147.16
26489	Transplant/graft palm tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26490	Revise thumb tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26492	Tendon transfer with graft.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26494	Hand tendon/muscle transfer.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26496	Revise thumb tendon.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26497	Finger tendon transfer.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26498	Finger tendon transfer.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26499	Revision of finger.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26500	Hand tendon reconstruction.				16.0343	$636.37	$633.19	$127.27	$126.64
26502	Hand tendon reconstruction.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26504	Hand tendon reconstruction.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26508	Release thumb contracture.				16.0343	$636.37	$573.19	$127.27	$114.64
26510	Thumb tendon transfer.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26516	Fusion of knuckle joint.				25.8425	$1,025.64	$679.32	$205.13	$135.86
26517	Fusion of knuckle joints.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26518	Fusion of knuckle joints.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26520	Release knuckle contracture.				16.0343	$636.37	$573.19	$127.27	$114.64
26525	Release finger contracture.				16.0343	$636.37	$573.19	$127.27	$114.64
26530	Revise knuckle joint.				32.7543	$1,299.96	$904.98	$259.99	$181.00

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
26531	Revise knuckle with implant.				47.1644	$1,871.86	$1,433.43	$374.37	$286.69
26535	Revise finger joint.				32.7543	$1,299.96	$1,008.48	$259.99	$201.70
26536	Revise/implant finger joint.				47.1644	$1,871.86	$1,294.43	$374.37	$258.89
26540	Repair hand joint.				16.0343	$636.37	$633.19	$127.27	$126.64
26541	Repair hand joint with graft.				25.8425	$1,025.64	$1,010.32	$205.13	$202.06
26542	Repair hand joint with graft.				16.0343	$636.37	$633.19	$127.27	$126.64
26545	Reconstruct finger joint.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26546	Repair nonunion hand.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26548	Reconstruct finger joint.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26550	Construct thumb replacement.				25.8425	$1,025.64	$735.82	$205.13	$147.16
26555	Positional change of finger.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26560	Repair of web finger.				16.0343	$636.37	$541.19	$127.27	$108.24
26561	Repair of web finger.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26562	Repair of web finger.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26565	Correct metacarpal flaw.				25.8425	$1,025.64	$871.32	$205.13	$174.26
26567	Correct finger deformity.				25.8425	$1,025.64	$871.32	$205.13	$174.26
26568	Lengthen metacarpal/finger.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26580	Repair hand deformity.				16.0343	$636.37	$676.69	$127.27	$135.34
26587	Reconstruct extra finger.				16.0343	$636.37	$676.69	$127.27	$135.34
26590	Repair finger deformity.				16.0343	$636.37	$676.69	$127.27	$135.34
26591	Repair muscles of hand.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26593	Release muscles of hand.				16.0343	$636.37	$573.19	$127.27	$114.64
26596	Excision constricting tissue.				16.0343	$636.37	$541.19	$127.27	$108.24
26600	Treat metacarpal fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
26605	Treat metacarpal fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
26607	Treat metacarpal fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
26608	Treat metacarpal fracture.				25.6702	$1,018.80	$824.40	$203.76	$164.88
26615	Treat metacarpal fracture.				37.5680	$1,491.00	$1,060.50	$298.20	$212.10
26641	Treat thumb dislocation.	Y			1.6914	$67.13	$67.13	$13.43	$13.43
26645	Treat thumb fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
26650	Treat thumb fracture.				25.6702	$1,018.80	$732.40	$203.76	$146.48

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
26665	Treat thumb fracture.				37.5680	$1,491.00	$1,060.50	$298.20	$212.10
26670	Treat hand dislocation.	Y			1.6914	$67.13	$67.13	$13.43	$13.43
26675	Treat hand dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
26676	Pin hand dislocation.				25.6702	$1,018.80	$732.40	$203.76	$146.48
26685	Treat hand dislocation.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
26686	Treat hand dislocation.				56.4195	$2,239.18	$1,374.59	$447.84	$274.92
26700	Treat knuckle dislocation.	Y			1.6914	$67.13	$67.13	$13.43	$13.43
26705	Treat knuckle dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
26706	Pin knuckle dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
26715	Treat knuckle dislocation.				37.5680	$1,491.00	$1,060.50	$298.20	$212.10
26720	Treat finger fracture, each.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
26725	Treat finger fracture, each.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
26727	Treat finger fracture, each.				25.6702	$1,018.80	$1,006.90	$203.76	$201.38
26735	Treat finger fracture, each.				37.5680	$1,491.00	$1,060.50	$298.20	$212.10
26740	Treat finger fracture, each.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
26742	Treat finger fracture, each.				1.6914	$67.13	$85.62	$13.43	$17.12
26746	Treat finger fracture, each.				37.5680	$1,491.00	$1,104.00	$298.20	$220.80
26750	Treat finger fracture, each.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
26755	Treat finger fracture, each.	Y			1.6914	$67.13	$67.13	$13.43	$13.43
26756	Pin finger fracture, each.				25.6702	$1,018.80	$732.40	$203.76	$146.48
26765	Treat finger fracture, each.				37.5680	$1,491.00	$1,060.50	$298.20	$212.10
26770	Treat finger dislocation.	Y			1.6914	$67.13	$67.13	$13.43	$13.43
26775	Treat finger dislocation.	Y			14.5502	$577.47	$577.47	$115.49	$115.49
26776	Pin finger dislocation.				25.6702	$1,018.80	$732.40	$203.76	$146.48
26785	Treat finger dislocation.				25.6702	$1,018.80	$732.40	$203.76	$146.48
26820	Thumb fusion with graft.				25.8425	$1,025.64	$871.32	$205.13	$174.26
26841	Fusion of thumb				25.8425	$1,025.64	$827.82	$205.13	$165.56
26842	Thumb fusion with graft.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26843	Fusion of hand joint.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26844	Fusion/graft of hand joint.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26850	Fusion of knuckle.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26852	Fusion of knuckle with graft.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26860	Fusion of finger joint.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26861	Fusion of finger jnt, add-on.				25.8425	$1,025.64	$735.82	$205.13	$147.16

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
26862	Fusion/graft of finger joint.				25.8425	$1,025.64	$827.82	$205.13	$165.56
26863	Fuse/graft added joint.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26910	Amputate metacarpal bone.				25.8425	$1,025.64	$767.82	$205.13	$153.56
26951	Amputation of finger/thumb.				16.0343	$636.37	$541.19	$127.27	$108.24
26952	Amputation of finger/thumb.				16.0343	$636.37	$633.19	$127.27	$126.64
26990	Drainage of pelvis lesion.				20.8214	$826.36	$579.68	$165.27	$115.94
26991	Drainage of pelvis bursa.				20.8214	$826.36	$579.68	$165.27	$115.94
27000	Incision of hip tendon.				20.8214	$826.36	$636.18	$165.27	$127.24
27001	Incision of hip tendon.				25.0600	$994.58	$752.29	$198.92	$150.46
27003	Incision of hip tendon.				25.0600	$994.58	$752.29	$198.92	$150.46
27033	Exploration of hip joint.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
27035	Denervation of hip joint.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
27040	Biopsy of soft tissues.				6.5128	$258.48	$295.74	$51.70	$59.15
27041	Biopsy of soft tissues.				6.5128	$258.48	$329.68	$51.70	$65.94
27047	Remove hip/pelvis lesion.				19.9760	$792.81	$619.40	$158.56	$123.88
27048	Remove hip/pelvis lesion.				19.9760	$792.81	$651.40	$158.56	$130.28
27049	Remove tumor, hip/pelvis.				19.9760	$792.81	$651.40	$158.56	$130.28
27050	Biopsy of sacroiliac joint.				20.8214	$826.36	$668.18	$165.27	$133.64
27052	Biopsy of hip joint.				20.8214	$826.36	$668.18	$165.27	$133.64
27060	Removal of ischial bursa.				20.8214	$826.36	$771.68	$165.27	$154.34
27062	Remove femur lesion/bursa.				20.8214	$826.36	$771.68	$165.27	$154.34
27065	Removal of hip bone lesion.				20.8214	$826.36	$771.68	$165.27	$154.34
27066	Removal of hip bone lesion.				25.0600	$994.58	$855.79	$198.92	$171.16
27067	Remove/graft hip bone lesion.				25.0600	$994.58	$855.79	$198.92	$171.16
27080	Removal of tail bone.				25.0600	$994.58	$720.29	$198.92	$144.06
27086	Remove hip foreign body.				6.5128	$258.48	$295.74	$51.70	$59.15
27087	Remove hip foreign body.				20.8214	$826.36	$668.18	$165.27	$133.64
27097	Revision of hip tendon.				25.0600	$994.58	$752.29	$198.92	$150.46
27098	Transfer tendon to pelvis.				25.0600	$994.58	$752.29	$198.92	$150.46
27100	Transfer of abdominal muscle.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
27105	Transfer of spinal muscle.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
27110	Transfer of iliopsoas muscle.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
27111	Transfer of iliopsoas muscle.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
27193	Treat pelvic ring fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27194	Treat pelvic ring fracture.				14.5502	$577.47	$511.73	$115.49	$102.35
27200	Treat tail bone fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
27202	Treat tail bone fracture.				37.5680	$1,491.00	$968.50	$298.20	$193.70
27230	Treat thigh fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27238	Treat thigh fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27246	Treat thigh fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27250	Treat hip dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
27252	Treat hip dislocation.				14.5502	$577.47	$511.73	$115.49	$102.35
27256	Treat hip dislocation.	Y			1.6914	$67.13	$67.13	$13.43	$13.43
27257	Treat hip dislocation.				14.5502	$577.47	$543.73	$115.49	$108.75
27265	Treat hip dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
27266	Treat hip dislocation.				14.5502	$577.47	$511.73	$115.49	$102.35
27275	Manipulation of hip joint.				14.5502	$577.47	$511.73	$115.49	$102.35
27301	Drain thigh/knee lesion.				17.4686	$693.30	$601.65	$138.66	$120.33
27305	Incise thigh tendon & fascia.				20.8214	$826.36	$636.18	$165.27	$127.24
27306	Incision of thigh tendon.				20.8214	$826.36	$668.18	$165.27	$133.64
27307	Incision of thigh tendons.				20.8214	$826.36	$668.18	$165.27	$133.64
27310	Exploration of knee joint.				25.0600	$994.58	$812.29	$198.92	$162.46
27315	Partial removal, thigh nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
27320	Partial removal, thigh nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
27323	Biopsy, thigh soft tissues.				6.5128	$258.48	$295.74	$51.70	$59.15
27324	Biopsy, thigh soft tissues.				19.9760	$792.81	$562.90	$158.56	$112.58
27327	Removal of thigh lesion.				19.9760	$792.81	$619.40	$158.56	$123.88
27328	Removal of thigh lesion.				19.9760	$792.81	$651.40	$158.56	$130.28
27329	Remove tumor, thigh/knee.				19.9760	$792.81	$711.40	$158.56	$142.28
27330	Biopsy, knee joint lining.				25.0600	$994.58	$812.29	$198.92	$162.46
27331	Explore/treat knee joint.				25.0600	$994.58	$812.29	$198.92	$162.46
27332	Removal of knee cartilage.				25.0600	$994.58	$812.29	$198.92	$162.46
27333	Removal of knee cartilage.				25.0600	$994.58	$812.29	$198.92	$162.46
27334	Remove knee joint lining.				25.0600	$994.58	$812.29	$198.92	$162.46
27335	Remove knee joint lining.				25.0600	$994.58	$812.29	$198.92	$162.46

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
27340	Removal of kneecap bursa.				20.8214	$826.36	$668.18	$165.27	$133.64
27345	Removal of knee cyst.				20.8214	$826.36	$728.18	$165.27	$145.64
27347	Remove knee cyst.				20.8214	$826.36	$728.18	$165.27	$145.64
27350	Removal of kneecap.				25.0600	$994.58	$812.29	$198.92	$162.46
27355	Remove femur lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
27356	Remove femur lesion/graft.				25.0600	$994.58	$812.29	$198.92	$162.46
27357	Remove femur lesion/graft.				25.0600	$994.58	$855.79	$198.92	$171.16
27358	Remove femur lesion/fixation.				25.0600	$994.58	$855.79	$198.92	$171.16
27360	Partial removal, leg bone(s).				25.0600	$994.58	$855.79	$198.92	$171.16
27372	Removal of foreign body.				19.9760	$792.81	$893.90	$158.56	$178.78
27380	Repair of kneecap tendon.				20.8214	$826.36	$579.68	$165.27	$115.94
27381	Repair/graft kneecap tendon.				20.8214	$826.36	$668.18	$165.27	$133.64
27385	Repair of thigh muscle.				20.8214	$826.36	$668.18	$165.27	$133.64
27386	Repair/graft of thigh muscle.				20.8214	$826.36	$668.18	$165.27	$133.64
27390	Incision of thigh tendon.				20.8214	$826.36	$579.68	$165.27	$115.94
27391	Incision of thigh tendons.				20.8214	$826.36	$636.18	$165.27	$127.24
27392	Incision of thigh tendons.				20.8214	$826.36	$668.18	$165.27	$133.64
27393	Lengthening of thigh tendon.				25.0600	$994.58	$720.29	$198.92	$144.06
27394	Lengthening of thigh tendons.				25.0600	$994.58	$752.29	$198.92	$150.46
27395	Lengthening of thigh tendons.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
27396	Transplant of thigh tendon.				25.0600	$994.58	$752.29	$198.92	$150.46
27397	Transplants of thigh tendons.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
27400	Revise thigh muscles/tendons.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
27403	Repair of knee cartilage.				25.0600	$994.58	$812.29	$198.92	$162.46
27405	Repair of knee ligament.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
27407	Repair of knee ligament.				65.8846	$2,614.83	$1,622.42	$522.97	$324.48
27409	Repair of knee ligaments.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
27418	Repair degenerated kneecap.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
27420	Revision of unstable kneecap.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
27422	Revision of unstable kneecap.				41.2543	$1,637.30	$1,316.15	$327.46	$263.23

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
27424	Revision/removal of kneecap.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
27425	Lat retinacular release open.				25.0600	$994.58	$994.79	$198.92	$198.96
27427	Reconstruction, knee.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
27428	Reconstruction, knee.				65.8846	$2,614.83	$1,622.42	$522.97	$324.48
27429	Reconstruction, knee.				65.8846	$2,614.83	$1,622.42	$522.97	$324.48
27430	Revision of thigh muscles.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
27435	Incision of knee joint.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
27437	Revise kneecap				32.7543	$1,299.96	$964.98	$259.99	$193.00
27438	Revise kneecap with implant.				47.1644	$1,871.86	$1,294.43	$374.37	$258.89
27441	Revision of knee joint.				32.7543	$1,299.96	$1,008.48	$259.99	$201.70
27442	Revision of knee joint.				32.7543	$1,299.96	$1,008.48	$259.99	$201.70
27443	Revision of knee joint.				32.7543	$1,299.96	$1,008.48	$259.99	$201.70
27496	Decompression of thigh/knee.				20.8214	$826.36	$771.68	$165.27	$154.34
27497	Decompression of thigh/knee.				20.8214	$826.36	$668.18	$165.27	$133.64
27498	Decompression of thigh/knee.				20.8214	$826.36	$668.18	$165.27	$133.64
27499	Decompression of thigh/knee.				20.8214	$826.36	$668.18	$165.27	$133.64
27500	Treatment of thigh fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27501	Treatment of thigh fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27502	Treatment of thigh fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27503	Treatment of thigh fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27508	Treatment of thigh fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27509	Treatment of thigh fracture.				25.6702	$1,018.80	$764.40	$203.76	$152.88
27510	Treatment of thigh fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27516	Treat thigh fx growth plate.				1.6914	$67.13	$85.62	$13.43	$17.12
27517	Treat thigh fx growth plate.				1.6914	$67.13	$85.62	$13.43	$17.12
27520	Treat kneecap fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27530	Treat knee fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27532	Treat knee fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27538	Treat knee fracture(s).				1.6914	$67.13	$85.62	$13.43	$17.12
27550	Treat knee dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
27552	Treat knee dislocation.				14.5502	$577.47	$455.23	$115.49	$91.05
27560	Treat kneecap dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
27562	Treat kneecap dislocation.				14.5502	$577.47	$455.23	$115.49	$91.05
27566	Treat kneecap dislocation.				37.5680	$1,491.00	$968.50	$298.20	$193.70

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
27570	Fixation of knee joint.				14.5502	$577.47	$455.23	$115.49	$91.05
27594	Amputation follow-up surgery.				20.8214	$826.36	$668.18	$165.27	$133.64
27600	Decompression of lower leg.				20.8214	$826.36	$668.18	$165.27	$133.64
27601	Decompression of lower leg.				20.8214	$826.36	$668.18	$165.27	$133.64
27602	Decompression of lower leg.				20.8214	$826.36	$668.18	$165.27	$133.64
27603	Drain lower leg lesion.				17.4686	$693.30	$569.65	$138.66	$113.93
27604	Drain lower leg bursa.				20.8214	$826.36	$636.18	$165.27	$127.24
27605	Incision of achilles tendon.				20.2255	$802.71	$567.86	$160.54	$113.57
27606	Incision of achilles tendon.				20.8214	$826.36	$579.68	$165.27	$115.94
27607	Treat lower leg bone lesion.				20.8214	$826.36	$636.18	$165.27	$127.24
27610	Explore/treat ankle joint.				25.0600	$994.58	$720.29	$198.92	$144.06
27612	Exploration of ankle joint.				25.0600	$994.58	$752.29	$198.92	$150.46
27613	Biopsy lower leg soft tissue.	Y	Y	Y	3.0423	$120.74	$120.74	$24.15	$24.15
27614	Biopsy lower leg soft tissue.				19.9760	$792.81	$619.40	$158.56	$123.88
27615	Remove tumor, lower leg.				25.0600	$994.58	$752.29	$198.92	$150.46
27618	Remove lower leg lesion.				14.9563	$593.59	$519.79	$118.72	$103.96
27619	Remove lower leg lesion.				19.9760	$792.81	$651.40	$158.56	$130.28
27620	Explore/treat ankle joint.				25.0600	$994.58	$812.29	$198.92	$162.46
27625	Remove ankle joint lining.				25.0600	$994.58	$812.29	$198.92	$162.46
27626	Remove ankle joint lining.				25.0600	$994.58	$812.29	$198.92	$162.46
27630	Removal of tendon lesion.				20.8214	$826.36	$668.18	$165.27	$133.64
27635	Remove lower leg bone lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
27637	Remove/graft leg bone lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
27638	Remove/graft leg bone lesion.				25.0600	$994.58	$752.29	$198.92	$150.46
27640	Partial removal of tibia.				41.2543	$1,637.30	$1,041.65	$327.46	$208.33
27641	Partial removal of fibula.				25.0600	$994.58	$720.29	$198.92	$144.06
27647	Extensive ankle/heel surgery.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
27650	Repair achilles tendon.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
27652	Repair/graft achilles tendon.				65.8846	$2,614.83	$1,562.42	$522.97	$312.48
27654	Repair of achilles tendon.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
27656	Repair leg fascia defect.				20.8214	$826.36	$636.18	$165.27	$127.24

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
27658	Repair of leg tendon, each.				20.8214	$826.36	$579.68	$165.27	$115.94
27659	Repair of leg tendon, each.				20.8214	$826.36	$636.18	$165.27	$127.24
27664	Repair of leg tendon, each.				20.8214	$826.36	$636.18	$165.27	$127.24
27665	Repair of leg tendon, each.				25.0600	$994.58	$720.29	$198.92	$144.06
27675	Repair lower leg tendons.				20.8214	$826.36	$636.18	$165.27	$127.24
27676	Repair lower leg tendons.				25.0600	$994.58	$752.29	$198.92	$150.46
27680	Release of lower leg tendon.				25.0600	$994.58	$752.29	$198.92	$150.46
27681	Release of lower leg tendons.				25.0600	$994.58	$720.29	$198.92	$144.06
27685	Revision of lower leg tendon.				25.0600	$994.58	$752.29	$198.92	$150.46
27686	Revise lower leg tendons.				25.0600	$994.58	$752.29	$198.92	$150.46
27687	Revision of calf tendon.				25.0600	$994.58	$752.29	$198.92	$150.46
27690	Revise lower leg tendon.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
27691	Revise lower leg tendon.				41.2543	$1,637.30	$1,133.65	$327.46	$226.73
27692	Revise additional leg tendon.				41.2543	$1,637.30	$1,073.65	$327.46	$214.73
27695	Repair of ankle ligament.				25.0600	$994.58	$720.29	$198.92	$144.06
27696	Repair of ankle ligaments.				25.0600	$994.58	$720.29	$198.92	$144.06
27698	Repair of ankle ligament.				25.0600	$994.58	$720.29	$198.92	$144.06
27700	Revision of ankle joint.				32.7543	$1,299.96	$1,008.48	$259.99	$201.70
27704	Removal of ankle implant.				20.8214	$826.36	$636.18	$165.27	$127.24
27705	Incision of tibia				41.2543	$1,637.30	$1,041.65	$327.46	$208.33
27707	Incision of fibula				20.8214	$826.36	$636.18	$165.27	$127.24
27709	Incision of tibia & fibula.				25.0600	$994.58	$720.29	$198.92	$144.06
27730	Repair of tibia epiphysis.				25.0600	$994.58	$720.29	$198.92	$144.06
27732	Repair of fibula epiphysis.				25.0600	$994.58	$720.29	$198.92	$144.06
27734	Repair lower leg epiphyses.				25.0600	$994.58	$720.29	$198.92	$144.06
27740	Repair of leg epiphyses.				25.0600	$994.58	$720.29	$198.92	$144.06
27742	Repair of leg epiphyses.				41.2543	$1,637.30	$1,041.65	$327.46	$208.33
27745	Reinforce tibia				65.8846	$2,614.83	$1,562.42	$522.97	$312.48
27750	Treatment of tibia fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27752	Treatment of tibia fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27756	Treatment of tibia fracture.				25.6702	$1,018.80	$764.40	$203.76	$152.88
27758	Treatment of tibia fracture.				37.5680	$1,491.00	$1,060.50	$298.20	$212.10
27759	Treatment of tibia fracture.				56.4195	$2,239.18	$1,434.59	$447.84	$286.92

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
27760	Treatment of ankle fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27762	Treatment of ankle fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27766	Treatment of ankle fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
27780	Treatment of fibula fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27781	Treatment of fibula fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27784	Treatment of fibula fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
27786	Treatment of ankle fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27788	Treatment of ankle fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27792	Treatment of ankle fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
27808	Treatment of ankle fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27810	Treatment of ankle fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27814	Treatment of ankle fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
27816	Treatment of ankle fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27818	Treatment of ankle fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27822	Treatment of ankle fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
27823	Treatment of ankle fracture.				56.4195	$2,239.18	$1,374.59	$447.84	$274.92
27824	Treat lower leg fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27825	Treat lower leg fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
27826	Treat lower leg fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
27827	Treat lower leg fracture.				56.4195	$2,239.18	$1,374.59	$447.84	$274.92
27828	Treat lower leg fracture.				56.4195	$2,239.18	$1,434.59	$447.84	$286.92
27829	Treat lower leg joint.				37.5680	$1,491.00	$968.50	$298.20	$193.70
27830	Treat lower leg dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
27831	Treat lower leg dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
27832	Treat lower leg dislocation.				37.5680	$1,491.00	$968.50	$298.20	$193.70
27840	Treat ankle dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
27842	Treat ankle dislocation.				14.5502	$577.47	$455.23	$115.49	$91.05
27846	Treat ankle dislocation.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
27848	Treat ankle dislocation.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
27860	Fixation of ankle joint.				14.5502	$577.47	$455.23	$115.49	$91.05
27870	Fusion of ankle joint, open.				65.8846	$2,614.83	$1,622.42	$522.97	$324.48
27871	Fusion of tibiofibular joint.				65.8846	$2,614.83	$1,622.42	$522.97	$324.48
27884	Amputation follow-up surgery.				20.8214	$826.36	$668.18	$165.27	$133.64

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
27889	Amputation of foot at ankle.				25.0600	$994.58	$752.29	$198.92	$150.46
27892	Decompression of leg.				20.8214	$826.36	$668.18	$165.27	$133.64
27893	Decompression of leg.				20.8214	$826.36	$668.18	$165.27	$133.64
27894	Decompression of leg.				20.8214	$826.36	$668.18	$165.27	$133.64
28001	Drainage of bursa of foot.	Y	Y	Y	2.9456	$116.90	$116.90	$23.38	$23.38
28002	Treatment of foot infection.				20.8214	$826.36	$668.18	$165.27	$133.64
28003	Treatment of foot infection.				20.8214	$826.36	$668.18	$165.27	$133.64
28005	Treat foot bone lesion.				20.2255	$802.71	$656.36	$160.54	$131.27
28008	Incision of foot fascia.				20.2255	$802.71	$656.36	$160.54	$131.27
28010	Incision of toe tendon.	Y	Y	Y	2.2064	$87.57	$87.57	$17.51	$17.51
28011	Incision of toe tendons.				20.2255	$802.71	$656.36	$160.54	$131.27
28020	Exploration of foot joint.				20.2255	$802.71	$624.36	$160.54	$124.87
28022	Exploration of foot joint.				20.2255	$802.71	$624.36	$160.54	$124.87
28024	Exploration of toe joint.				20.2255	$802.71	$624.36	$160.54	$124.87
28030	Removal of foot nerve.				17.7609	$704.90	$667.45	$140.98	$133.49
28035	Decompression of tibia nerve.				17.7609	$704.90	$667.45	$140.98	$133.49
28043	Excision of foot lesion.				19.9760	$792.81	$619.40	$158.56	$123.88
28045	Excision of foot lesion.				20.2255	$802.71	$656.36	$160.54	$131.27
28046	Resection of tumor, foot.				20.2255	$802.71	$656.36	$160.54	$131.27
28050	Biopsy of foot joint lining.				20.2255	$802.71	$624.36	$160.54	$124.87
28052	Biopsy of foot joint lining.				20.2255	$802.71	$624.36	$160.54	$124.87
28054	Biopsy of toe joint lining.				20.2255	$802.71	$624.36	$160.54	$124.87
28060	Partial removal, foot fascia.				20.2255	$802.71	$624.36	$160.54	$124.87
28062	Removal of foot fascia.				20.2255	$802.71	$656.36	$160.54	$131.27
28070	Removal of foot joint lining.				20.2255	$802.71	$656.36	$160.54	$131.27
28072	Removal of foot joint lining.				20.2255	$802.71	$656.36	$160.54	$131.27
28080	Removal of foot lesion.				20.2255	$802.71	$656.36	$160.54	$131.27
28086	Excise foot tendon sheath.				20.2255	$802.71	$624.36	$160.54	$124.87
28088	Excise foot tendon sheath.				20.2255	$802.71	$624.36	$160.54	$124.87
28090	Removal of foot lesion.				20.2255	$802.71	$656.36	$160.54	$131.27
28092	Removal of toe lesions.				20.2255	$802.71	$656.36	$160.54	$131.27
28100	Removal of ankle/heel lesion.				20.2255	$802.71	$624.36	$160.54	$124.87
28102	Remove/graft foot lesion.				41.2239	$1,636.10	$1,073.05	$327.22	$214.61

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
28103	Remove/graft foot lesion.				41.2239	$1,636.10	$1,073.05	$327.22	$214.61
28104	Removal of foot lesion.				20.2255	$802.71	$624.36	$160.54	$124.87
28106	Remove/graft foot lesion.				41.2239	$1,636.10	$1,073.05	$327.22	$214.61
28107	Remove/graft foot lesion.				41.2239	$1,636.10	$1,073.05	$327.22	$214.61
28108	Removal of toe lesions.				20.2255	$802.71	$624.36	$160.54	$124.87
28110	Part removal of metatarsal.				20.2255	$802.71	$656.36	$160.54	$131.27
28111	Part removal of metatarsal.				20.2255	$802.71	$656.36	$160.54	$131.27
28112	Part removal of metatarsal.				20.2255	$802.71	$656.36	$160.54	$131.27
28113	Part removal of metatarsal.				20.2255	$802.71	$656.36	$160.54	$131.27
28114	Removal of metatarsal heads.				20.2255	$802.71	$656.36	$160.54	$131.27
28116	Revision of foot				20.2255	$802.71	$656.36	$160.54	$131.27
28118	Removal of heel bone.				20.2255	$802.71	$716.36	$160.54	$143.27
28119	Removal of heel spur.				20.2255	$802.71	$716.36	$160.54	$143.27
28120	Part removal of ankle/heel.				20.2255	$802.71	$898.86	$160.54	$179.77
28122	Partial removal of foot bone.				20.2255	$802.71	$656.36	$160.54	$131.27
28124	Partial removal of toe.	Y	Y	Y	4.9541	$196.62	$196.62	$39.32	$39.32
28126	Partial removal of toe.				20.2255	$802.71	$656.36	$160.54	$131.27
28130	Removal of ankle bone.				20.2255	$802.71	$656.36	$160.54	$131.27
28140	Removal of metatarsal.				20.2255	$802.71	$656.36	$160.54	$131.27
28150	Removal of toe				20.2255	$802.71	$656.36	$160.54	$131.27
28153	Partial removal of toe.				20.2255	$802.71	$656.36	$160.54	$131.27
28160	Partial removal of toe.				20.2255	$802.71	$656.36	$160.54	$131.27
28171	Extensive foot surgery.				20.2255	$802.71	$656.36	$160.54	$131.27
28173	Extensive foot surgery.				20.2255	$802.71	$656.36	$160.54	$131.27
28175	Extensive foot surgery.				20.2255	$802.71	$656.36	$160.54	$131.27
28190	Removal of foot foreign body.	Y	Y	Y	3.1309	$124.26	$124.26	$24.85	$24.85
28192	Removal of foot foreign body.				14.9563	$593.59	$519.79	$118.72	$103.96
28193	Removal of foot foreign body.				6.5128	$258.48	$329.68	$51.70	$65.94
28200	Repair of foot tendon.				20.2255	$802.71	$656.36	$160.54	$131.27
28202	Repair/graft of foot tendon.				20.2255	$802.71	$656.36	$160.54	$131.27
28208	Repair of foot tendon.				20.2255	$802.71	$656.36	$160.54	$131.27
28210	Repair/graft of foot tendon.				41.2239	$1,636.10	$1,073.05	$327.22	$214.61
28220	Release of foot tendon.	Y	Y	Y	4.6712	$185.39	$185.39	$37.08	$37.08
28222	Release of foot tendons.				20.2255	$802.71	$567.86	$160.54	$113.57

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
28225	Release of foot tendon.				20.2255	$802.71	$567.86	$160.54	$113.57
28226	Release of foot tendons.				20.2255	$802.71	$567.86	$160.54	$113.57
28230	Incision of foot tendon(s).	Y	Y	Y	4.6363	$184.00	$184.00	$36.80	$36.80
28232	Incision of toe tendon.	Y	Y	Y	4.4311	$175.86	$175.86	$35.17	$35.17
28234	Incision of foot tendon.				20.2255	$802.71	$624.36	$160.54	$124.87
28238	Revision of foot tendon.				41.2239	$1,636.10	$1,073.05	$327.22	$214.61
28240	Release of big toe.				20.2255	$802.71	$624.36	$160.54	$124.87
28250	Revision of foot fascia.				20.2255	$802.71	$656.36	$160.54	$131.27
28260	Release of midfoot joint.				20.2255	$802.71	$656.36	$160.54	$131.27
28261	Revision of foot tendon.				20.2255	$802.71	$656.36	$160.54	$131.27
28262	Revision of foot and ankle.				20.2255	$802.71	$716.36	$160.54	$143.27
28264	Release of midfoot joint.				41.2239	$1,636.10	$984.55	$327.22	$196.91
28270	Release of foot contracture.				20.2255	$802.71	$656.36	$160.54	$131.27
28272	Release of toe joint, each.	Y	Y	Y	4.2127	$167.19	$167.19	$33.44	$33.44
28280	Fusion of toes				20.2255	$802.71	$624.36	$160.54	$124.87
28285	Repair of hammertoe.				20.2255	$802.71	$656.36	$160.54	$131.27
28286	Repair of hammertoe.				20.2255	$802.71	$716.36	$160.54	$143.27
28288	Partial removal of foot bone.				20.2255	$802.71	$656.36	$160.54	$131.27
28289	Repair hallux rigidus.				20.2255	$802.71	$656.36	$160.54	$131.27
28290	Correction of bunion.				28.0970	$1,115.12	$780.56	$223.02	$156.11
28292	Correction of bunion.				28.0970	$1,115.12	$780.56	$223.02	$156.11
28293	Correction of bunion.				28.0970	$1,115.12	$812.56	$223.02	$162.51
28294	Correction of bunion.				28.0970	$1,115.12	$812.56	$223.02	$162.51
28296	Correction of bunion.				28.0970	$1,115.12	$812.56	$223.02	$162.51
28297	Correction of bunion.				28.0970	$1,115.12	$812.56	$223.02	$162.51
28298	Correction of bunion.				28.0970	$1,115.12	$812.56	$223.02	$162.51
28299	Correction of bunion.				28.0970	$1,115.12	$916.06	$223.02	$183.21
28300	Incision of heel bone.				41.2239	$1,636.10	$1,041.05	$327.22	$208.21
28302	Incision of ankle bone.				20.2255	$802.71	$624.36	$160.54	$124.87
28304	Incision of midfoot bones.				41.2239	$1,636.10	$1,041.05	$327.22	$208.21
28305	Incise/graft midfoot bones.				41.2239	$1,636.10	$1,073.05	$327.22	$214.61
28306	Incision of metatarsal.				20.2255	$802.71	$716.36	$160.54	$143.27
28307	Incision of metatarsal.				20.2255	$802.71	$716.36	$160.54	$143.27
28308	Incision of metatarsal.				20.2255	$802.71	$624.36	$160.54	$124.87

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
28309	Incision of metatarsals.				41.2239	$1,636.10	$1,133.05	$327.22	$226.61
28310	Revision of big toe.				20.2255	$802.71	$656.36	$160.54	$131.27
28312	Revision of toe				20.2255	$802.71	$656.36	$160.54	$131.27
28313	Repair deformity of toe.				20.2255	$802.71	$624.36	$160.54	$124.87
28315	Removal of sesamoid bone.				20.2255	$802.71	$716.36	$160.54	$143.27
28320	Repair of foot bones.				41.2239	$1,636.10	$1,133.05	$327.22	$226.61
28322	Repair of metatarsals.				41.2239	$1,636.10	$1,133.05	$327.22	$226.61
28340	Resect enlarged toe tissue.				20.2255	$802.71	$716.36	$160.54	$143.27
28341	Resect enlarged toe.				20.2255	$802.71	$716.36	$160.54	$143.27
28344	Repair extra toe(s).				20.2255	$802.71	$716.36	$160.54	$143.27
28345	Repair webbed toe(s).				20.2255	$802.71	$716.36	$160.54	$143.27
28400	Treatment of heel fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
28405	Treatment of heel fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
28406	Treatment of heel fracture.				25.6702	$1,018.80	$732.40	$203.76	$146.48
28415	Treat heel fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
28420	Treat/graft heel fracture.				37.5680	$1,491.00	$1,060.50	$298.20	$212.10
28430	Treatment of ankle fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
28435	Treatment of ankle fracture.				1.6914	$67.13	$85.62	$13.43	$17.12
28436	Treatment of ankle fracture.				25.6702	$1,018.80	$732.40	$203.76	$146.48
28445	Treat ankle fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
28450	Treat midfoot fracture, each.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
28455	Treat midfoot fracture, each.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
28456	Treat midfoot fracture.				25.6702	$1,018.80	$732.40	$203.76	$146.48
28465	Treat midfoot fracture, each.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
28470	Treat metatarsal fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
28475	Treat metatarsal fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
28476	Treat metatarsal fracture.				25.6702	$1,018.80	$732.40	$203.76	$146.48
28485	Treat metatarsal fracture.				37.5680	$1,491.00	$1,060.50	$298.20	$212.10
28490	Treat big toe fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
28495	Treat big toe fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
28496	Treat big toe fracture.				25.6702	$1,018.80	$732.40	$203.76	$146.48
28505	Treat big toe fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
28510	Treatment of toe fracture.	Y	Y	Y	1.3651	$54.18	$54.18	$10.84	$10.84
28515	Treatment of toe fracture.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
28525	Treat toe fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
28530	Treat sesamoid bone fracture.	Y	Y	Y	1.3078	$51.90	$51.90	$10.38	$10.38
28531	Treat sesamoid bone fracture.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
28540	Treat foot dislocation.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
28545	Treat foot dislocation.				25.6702	$1,018.80	$675.90	$203.76	$135.18
28546	Treat foot dislocation.				25.6702	$1,018.80	$732.40	$203.76	$146.48
28555	Repair foot dislocation.				37.5680	$1,491.00	$968.50	$298.20	$193.70
28570	Treat foot dislocation.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
28575	Treat foot dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
28576	Treat foot dislocation.				25.6702	$1,018.80	$764.40	$203.76	$152.88
28585	Repair foot dislocation.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
28600	Treat foot dislocation.	Y	Y		1.6914	$67.13	$67.13	$13.43	$13.43
28605	Treat foot dislocation.				1.6914	$67.13	$85.62	$13.43	$17.12
28606	Treat foot dislocation.				25.6702	$1,018.80	$732.40	$203.76	$146.48
28615	Repair foot dislocation.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
28630	Treat toe dislocation.	Y			1.6914	$67.13	$67.13	$13.43	$13.43
28635	Treat toe dislocation.				14.5502	$577.47	$455.23	$115.49	$91.05
28636	Treat toe dislocation.				25.6702	$1,018.80	$764.40	$203.76	$152.88
28645	Repair toe dislocation.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
28660	Treat toe dislocation.	Y			1.6914	$67.13	$67.13	$13.43	$13.43
28665	Treat toe dislocation.				14.5502	$577.47	$455.23	$115.49	$91.05
28666	Treat toe dislocation.				25.6702	$1,018.80	$764.40	$203.76	$152.88
28675	Repair of toe dislocation.				37.5680	$1,491.00	$1,000.50	$298.20	$200.10
28705	Fusion of foot bones.				41.2239	$1,636.10	$1,133.05	$327.22	$226.61
28715	Fusion of foot bones.				41.2239	$1,636.10	$1,133.05	$327.22	$226.61
28725	Fusion of foot bones.				41.2239	$1,636.10	$1,133.05	$327.22	$226.61
28730	Fusion of foot bones.				41.2239	$1,636.10	$1,133.05	$327.22	$226.61
28735	Fusion of foot bones.				41.2239	$1,636.10	$1,133.05	$327.22	$226.61
28737	Revision of foot bones.				41.2239	$1,636.10	$1,176.55	$327.22	$235.31
28740	Fusion of foot bones.				41.2239	$1,636.10	$1,133.05	$327.22	$226.61
28750	Fusion of big toe joint.				41.2239	$1,636.10	$1,133.05	$327.22	$226.61
28755	Fusion of big toe joint.				20.2255	$802.71	$716.36	$160.54	$143.27
28760	Fusion of big toe joint.				41.2239	$1,636.10	$1,133.05	$327.22	$226.61
28810	Amputation toe & metatarsal.				20.2255	$802.71	$624.36	$160.54	$124.87

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
28820	Amputation of toe.				20.2255	$802.71	$624.36	$160.54	$124.87
28825	Partial amputation of toe.				20.2255	$802.71	$624.36	$160.54	$124.87
28890	High energy eswt, plantar f.	Y			25.0600	$994.58	$994.58	$198.92	$198.92
29010	Application of body cast.	Y	Y		2.2728	$90.20	$90.20	$18.04	$18.04
29015	Application of body cast.	Y	Y		2.2728	$90.20	$90.20	$18.04	$18.04
29020	Application of body cast.	Y			1.0504	$41.69	$41.69	$8.34	$8.34
29025	Application of body cast.	Y	Y		1.0504	$41.69	$41.69	$8.34	$8.34
29035	Application of body cast.	Y			2.2728	$90.20	$90.20	$18.04	$18.04
29040	Application of body cast.	Y			1.0504	$41.69	$41.69	$8.34	$8.34
29044	Application of body cast.	Y	Y		2.2728	$90.20	$90.20	$18.04	$18.04
29049	Application of figure eight.	Y	Y		1.0504	$41.69	$41.69	$8.34	$8.34
29055	Application of shoulder cast.	Y	Y		2.2728	$90.20	$90.20	$18.04	$18.04
29058	Application of shoulder cast.	Y	Y		1.0504	$41.69	$41.69	$8.34	$8.34
29065	Application of long arm cast.	Y	Y	Y	1.1406	$45.27	$45.27	$9.05	$9.05
29075	Application of forearm cast.	Y	Y	Y	1.0379	$41.19	$41.19	$8.24	$8.24
29085	Apply hand/wrist cast.	Y	Y		1.0504	$41.69	$41.69	$8.34	$8.34
29086	Apply finger cast.	Y	Y	Y	0.8720	$34.61	$34.61	$6.92	$6.92
29105	Apply long arm splint.	Y	Y	Y	1.0024	$39.78	$39.78	$7.96	$7.96
29125	Apply forearm splint.	Y	Y	Y	0.8527	$33.84	$33.84	$6.77	$6.77
29126	Apply forearm splint.	Y	Y	Y	0.9572	$37.99	$37.99	$7.60	$7.60
29130	Application of finger splint.	Y	Y	Y	0.3862	$15.33	$15.33	$3.07	$3.07
29131	Application of finger splint.	Y	Y	Y	0.5869	$23.29	$23.29	$4.66	$4.66
29200	Strapping of chest.	Y	Y	Y	0.5597	$22.21	$22.21	$4.44	$4.44
29220	Strapping of low back.	Y	Y	Y	0.5669	$22.50	$22.50	$4.50	$4.50
29240	Strapping of shoulder.	Y	Y	Y	0.6464	$25.66	$25.66	$5.13	$5.13
29260	Strapping of elbow or wrist.	Y	Y	Y	0.5940	$23.58	$23.58	$4.72	$4.72
29280	Strapping of hand or finger.	Y	Y	Y	0.6225	$24.70	$24.70	$4.94	$4.94
29305	Application of hip cast.	Y			2.2728	$90.20	$90.20	$18.04	$18.04
29325	Application of hip casts.	Y			2.2728	$90.20	$90.20	$18.04	$18.04
29345	Application of long leg cast.	Y	Y	Y	1.5007	$59.56	$59.56	$11.91	$11.91
29355	Application of long leg cast.	Y	Y	Y	1.4561	$57.79	$57.79	$11.56	$11.56
29358	Apply long leg cast brace.	Y	Y	Y	1.7938	$71.19	$71.19	$14.24	$14.24
29365	Application of long leg cast.	Y	Y	Y	1.4129	$56.08	$56.08	$11.22	$11.22
29405	Apply short leg cast.	Y	Y	Y	1.0527	$41.78	$41.78	$8.36	$8.36

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
29425	Apply short leg cast.	Y	Y	Y	1.0639	$42.22	$42.22	$8.44	$8.44
29435	Apply short leg cast.	Y	Y	Y	1.3502	$53.59	$53.59	$10.72	$10.72
29440	Addition of walker to cast.	Y	Y	Y	0.5600	$22.23	$22.23	$4.45	$4.45
29445	Apply rigid leg cast.	Y	Y	Y	1.4713	$58.39	$58.39	$11.68	$11.68
29450	Application of leg cast.	Y	Y		1.0504	$41.69	$41.69	$8.34	$8.34
29505	Application, long leg splint.	Y			1.0504	$41.69	$41.69	$8.34	$8.34
29515	Application lower leg splint.	Y			1.0504	$41.69	$41.69	$8.34	$8.34
29520	Strapping of hip	Y	Y	Y	0.6469	$25.67	$25.67	$5.13	$5.13
29530	Strapping of knee.	Y	Y	Y	0.6104	$24.23	$24.23	$4.85	$4.85
29540	Strapping of ankle and/or ft.	Y	Y	Y	0.4057	$16.10	$16.10	$3.22	$3.22
29550	Strapping of toes.	Y	Y	Y	0.4128	$16.38	$16.38	$3.28	$3.28
29580	Application of paste boot.	Y	Y	Y	0.5844	$23.19	$23.19	$4.64	$4.64
29590	Application of foot splint.	Y	Y	Y	0.4639	$18.41	$18.41	$3.68	$3.68
29700	Removal/revision of cast.	Y	Y	Y	0.7997	$31.74	$31.74	$6.35	$6.35
29705	Removal/revision of cast.	Y	Y	Y	0.6912	$27.43	$27.43	$5.49	$5.49
29710	Removal/revision of cast.	Y	Y	Y	1.3029	$51.71	$51.71	$10.34	$10.34
29715	Removal/revision of cast.	Y	Y	Y	1.0504	$41.69	$41.69	$8.34	$8.34
29720	Repair of body cast.	Y	Y	Y	1.0084	$40.02	$40.02	$8.00	$8.00
29730	Windowing of cast.	Y	Y	Y	0.6775	$26.89	$26.89	$5.38	$5.38
29740	Wedging of cast	Y	Y	Y	0.9533	$37.83	$37.83	$7.57	$7.57
29750	Wedging of clubfoot cast.	Y	Y	Y	0.8453	$33.55	$33.55	$6.71	$6.71
29800	Jaw arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29804	Jaw arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29805	Shoulder arthroscopy, dx.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29806	Shoulder arthroscopy/surgery.				45.0637	$1,788.49	$1,149.25	$357.70	$229.85
29807	Shoulder arthroscopy/surgery.				45.0637	$1,788.49	$1,149.25	$357.70	$229.85
29819	Shoulder arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29820	Shoulder arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29821	Shoulder arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29822	Shoulder arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
29823	Shoulder arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29824	Shoulder arthroscopy/surgery.				28.6279	$1,136.19	$926.59	$227.24	$185.32
29825	Shoulder arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29826	Shoulder arthroscopy/surgery.				45.0637	$1,788.49	$1,149.25	$357.70	$229.85
29827	Arthroscop rotator cuff repr.				45.0637	$1,788.49	$1,252.75	$357.70	$250.55
29830	Elbow arthroscopy.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29834	Elbow arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29835	Elbow arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29836	Elbow arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29837	Elbow arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29838	Elbow arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29840	Wrist arthroscopy.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29843	Wrist arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29844	Wrist arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29845	Wrist arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29846	Wrist arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29847	Wrist arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29848	Wrist endoscopy/surgery.				28.6279	$1,136.19	$1,237.59	$227.24	$247.52
29850	Knee arthroscopy/surgery.				28.6279	$1,136.19	$883.09	$227.24	$176.62
29851	Knee arthroscopy/surgery.				45.0637	$1,788.49	$1,209.25	$357.70	$241.85
29855	Tibial arthroscopy/surgery.				45.0637	$1,788.49	$1,209.25	$357.70	$241.85
29856	Tibial arthroscopy/surgery.				28.6279	$1,136.19	$883.09	$227.24	$176.62
29860	Hip arthroscopy, dx.				28.6279	$1,136.19	$883.09	$227.24	$176.62
29861	Hip arthroscopy/surgery.				28.6279	$1,136.19	$883.09	$227.24	$176.62
29862	Hip arthroscopy/surgery.				45.0637	$1,788.49	$1,563.75	$357.70	$312.75
29863	Hip arthroscopy/surgery.				45.0637	$1,788.49	$1,209.25	$357.70	$241.85
29866	Autgrft implnt, knee w/scope.	Y			45.0637	$1,788.49	$1,788.49	$357.70	$357.70
29870	Knee arthroscopy, dx.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29871	Knee arthroscopy/drainage.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29873	Knee arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29874	Knee arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29875	Knee arthroscopy/surgery.				28.6279	$1,136.19	$883.09	$227.24	$176.62

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
29876	Knee arthroscopy/surgery.				28.6279	$1,136.19	$883.09	$227.24	$176.62
29877	Knee arthroscopy/surgery.				28.6279	$1,136.19	$883.09	$227.24	$176.62
29879	Knee arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29880	Knee arthroscopy/surgery.				28.6279	$1,136.19	$883.09	$227.24	$176.62
29881	Knee arthroscopy/surgery.				28.6279	$1,136.19	$883.09	$227.24	$176.62
29882	Knee arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29883	Knee arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29884	Knee arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29885	Knee arthroscopy/surgery.				45.0637	$1,788.49	$1,149.25	$357.70	$229.85
29886	Knee arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29887	Knee arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29888	Knee arthroscopy/surgery.				45.0637	$1,788.49	$1,149.25	$357.70	$229.85
29889	Knee arthroscopy/surgery.				45.0637	$1,788.49	$1,149.25	$357.70	$229.85
29891	Ankle arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29892	Ankle arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29893	Scope, plantar fasciotomy.				20.2255	$802.71	$1,023.81	$160.54	$204.76
29894	Ankle arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29895	Ankle arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29897	Ankle arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29898	Ankle arthroscopy/surgery.				28.6279	$1,136.19	$823.09	$227.24	$164.62
29899	Ankle arthroscopy/surgery.				45.0637	$1,788.49	$1,149.25	$357.70	$229.85
29900	Mcp joint arthroscopy, dx.				16.0343	$636.37	$573.19	$127.27	$114.64
29901	Mcp joint arthroscopy, surg.				16.0343	$636.37	$573.19	$127.27	$114.64
29902	Mcp joint arthroscopy, surg.				16.0343	$636.37	$573.19	$127.27	$114.64
30000	Drainage of nose lesion.	Y	Y		2.3768	$94.33	$94.33	$18.87	$18.87
30020	Drainage of nose lesion.	Y	Y		2.3768	$94.33	$94.33	$18.87	$18.87
30100	Intranasal biopsy.	Y	Y	Y	1.9302	$76.60	$76.60	$15.32	$15.32
30110	Removal of nose polyp(s).	Y	Y	Y	3.0207	$119.89	$119.89	$23.98	$23.98
30115	Removal of nose polyp(s).				16.4494	$652.85	$549.42	$130.57	$109.88
30117	Removal of intranasal lesion.				16.4494	$652.85	$581.42	$130.57	$116.28
30118	Removal of intranasal lesion.				23.1564	$919.03	$714.52	$183.81	$142.90
30120	Revision of nose.				16.4494	$652.85	$492.92	$130.57	$98.58

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
30124	Removal of nose lesion.	Y	Y	Y	3.1426	$124.72	$124.72	$24.94	$24.94
30125	Removal of nose lesion.				37.7719	$1,499.09	$972.55	$299.82	$194.51
30130	Excise inferior turbinate.				16.4494	$652.85	$581.42	$130.57	$116.28
30140	Resect inferior turbinate.				23.1564	$919.03	$682.52	$183.81	$136.50
30150	Partial removal of nose.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
30160	Removal of nose.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
30200	Injection treatment of nose.	Y	Y	Y	1.5377	$61.03	$61.03	$12.21	$12.21
30210	Nasal sinus therapy.	Y	Y	Y	1.9430	$77.11	$77.11	$15.42	$15.42
30220	Insert nasal septal button.				7.7261	$306.63	$391.09	$61.33	$78.22
30300	Remove nasal foreign body.	Y	Y		0.6211	$24.65	$24.65	$4.93	$4.93
30310	Remove nasal foreign body.				16.4494	$652.85	$492.92	$130.57	$98.58
30320	Remove nasal foreign body.				16.4494	$652.85	$549.42	$130.57	$109.88
30400	Reconstruction of nose.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
30410	Reconstruction of nose.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
30420	Reconstruction of nose.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
30430	Revision of nose.				23.1564	$919.03	$714.52	$183.81	$142.90
30435	Revision of nose.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
30450	Revision of nose.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
30460	Revision of nose.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
30462	Revision of nose.				37.7719	$1,499.09	$1,419.05	$299.82	$283.81
30465	Repair nasal stenosis.				37.7719	$1,499.09	$1,419.05	$299.82	$283.81
30520	Repair of nasal septum.				23.1564	$919.03	$774.52	$183.81	$154.90
30540	Repair nasal defect.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
30545	Repair nasal defect.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
30560	Release of nasal adhesions.				2.3768	$94.33	$120.31	$18.87	$24.06
30580	Repair upper jaw fistula.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
30600	Repair mouth/nose fistula.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
30620	Intranasal reconstruction.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
30630	Repair nasal septum defect.				23.1564	$919.03	$957.02	$183.81	$191.40
30801	Ablate inf turbinate, superf.				7.7261	$306.63	$319.82	$61.33	$63.96
30802	Cauterization, inner nose.				7.7261	$306.63	$319.82	$61.33	$63.96
30901	Control of nosebleed.	Y	Y	Y	1.1029	$43.77	$43.77	$8.75	$8.75
30903	Control of nosebleed.				1.2021	$47.71	$60.85	$9.54	$12.17

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
30905	Control of nosebleed.				1.2021	$47.71	$60.85	$9.54	$12.17
30906	Repeat control of nosebleed.				1.2021	$47.71	$60.85	$9.54	$12.17
30915	Ligation, nasal sinus artery.				24.5817	$975.60	$710.80	$195.12	$142.16
30920	Ligation, upper jaw artery.				24.5817	$975.60	$742.80	$195.12	$148.56
30930	Ther fx, nasal inf turbinate.				16.4494	$652.85	$641.42	$130.57	$128.28
31000	Irrigation, maxillary sinus.	Y	Y		2.3768	$94.33	$94.33	$18.87	$18.87
31002	Irrigation, sphenoid sinus.	Y	Y	Y	2.4899	$98.82	$98.82	$19.76	$19.76
31020	Exploration, maxillary sinus.				23.1564	$919.03	$682.52	$183.81	$136.50
31030	Exploration, maxillary sinus.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
31032	Explore sinus, remove polyps.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
31040	Exploration behind upper jaw.	Y	Y	Y	7.3501	$291.71	$291.71	$58.34	$58.34
31050	Exploration, sphenoid sinus.				37.7719	$1,499.09	$972.55	$299.82	$194.51
31051	Sphenoid sinus surgery.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
31070	Exploration of frontal sinus.				23.1564	$919.03	$682.52	$183.81	$136.50
31075	Exploration of frontal sinus.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
31080	Removal of frontal sinus.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
31081	Removal of frontal sinus.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
31084	Removal of frontal sinus.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
31085	Removal of frontal sinus.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
31086	Removal of frontal sinus.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
31087	Removal of frontal sinus.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
31090	Exploration of sinuses.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
31200	Removal of ethmoid sinus.				37.7719	$1,499.09	$972.55	$299.82	$194.51
31201	Removal of ethmoid sinus.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
31205	Removal of ethmoid sinus.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
31231	Nasal endoscopy, dx.	Y	Y		1.4038	$55.71	$55.71	$11.14	$11.14
31233	Nasal/sinus endoscopy, dx.				1.4038	$55.71	$71.06	$11.14	$14.21
31235	Nasal/sinus endoscopy, dx.				15.1300	$600.48	$466.74	$120.10	$93.35
31237	Nasal/sinus endoscopy, surg.				15.1300	$600.48	$523.24	$120.10	$104.65
31238	Nasal/sinus endoscopy, surg.				15.1300	$600.48	$466.74	$120.10	$93.35
31239	Nasal/sinus endoscopy, surg.				21.8010	$865.24	$747.62	$173.05	$149.52

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
31240	Nasal/sinus endoscopy, surg.				15.1300	$600.48	$523.24	$120.10	$104.65
31254	Revision of ethmoid sinus.				21.8010	$865.24	$687.62	$173.05	$137.52
31255	Removal of ethmoid sinus.				21.8010	$865.24	$791.12	$173.05	$158.22
31256	Exploration maxillary sinus.				21.8010	$865.24	$687.62	$173.05	$137.52
31267	Endoscopy, maxillary sinus.				21.8010	$865.24	$687.62	$173.05	$137.52
31276	Sinus endoscopy, surgical.				21.8010	$865.24	$687.62	$173.05	$137.52
31287	Nasal/sinus endoscopy, surg.				21.8010	$865.24	$687.62	$173.05	$137.52
31288	Nasal/sinus endoscopy, surg.				21.8010	$865.24	$687.62	$173.05	$137.52
31300	Removal of larynx lesion.				23.1564	$919.03	$818.02	$183.81	$163.60
31320	Diagnostic incision, larynx.				37.7719	$1,499.09	$972.55	$299.82	$194.51
31400	Revision of larynx.				37.7719	$1,499.09	$972.55	$299.82	$194.51
31420	Removal of epiglottis.				37.7719	$1,499.09	$972.55	$299.82	$194.51
31502	Change of windpipe airway.	Y			2.3431	$92.99	$92.99	$18.60	$18.60
31505	Diagnostic laryngoscopy.	Y	Y		0.7572	$30.05	$30.05	$6.01	$6.01
31510	Laryngoscopy with biopsy.				15.1300	$600.48	$523.24	$120.10	$104.65
31511	Remove foreign body, larynx.				1.4038	$55.71	$71.06	$11.14	$14.21
31512	Removal of larynx lesion.				15.1300	$600.48	$523.24	$120.10	$104.65
31513	Injection into vocal cord.				1.4038	$55.71	$71.06	$11.14	$14.21
31515	Laryngoscopy for aspiration.				15.1300	$600.48	$466.74	$120.10	$93.35
31520	Diagnostic laryngoscopy.	Y			1.4038	$55.71	$55.71	$11.14	$11.14
31525	Dx laryngoscopy excl nb.				15.1300	$600.48	$466.74	$120.10	$93.35
31526	Dx laryngoscopy w/oper scope.				21.8010	$865.24	$655.62	$173.05	$131.12
31527	Laryngoscopy for treatment.				21.8010	$865.24	$599.12	$173.05	$119.82
31528	Laryngoscopy and dilation.				15.1300	$600.48	$523.24	$120.10	$104.65
31529	Laryngoscopy and dilation.				15.1300	$600.48	$523.24	$120.10	$104.65
31530	Laryngoscopy w/fb removal.				21.8010	$865.24	$655.62	$173.05	$131.12
31531	Laryngoscopy w/fb & op scope.				21.8010	$865.24	$687.62	$173.05	$137.52
31535	Laryngoscopy w/biopsy.				21.8010	$865.24	$655.62	$173.05	$131.12
31536	Laryngoscopy w/bx & op scope.				21.8010	$865.24	$687.62	$173.05	$137.52
31540	Laryngoscopy w/exc of tumor.				21.8010	$865.24	$687.62	$173.05	$137.52

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
31541	Larynscop w/ tumr exc + scope.				21.8010	$865.24	$747.62	$173.05	$149.52
31545	Remove vc lesion w/scope.				21.8010	$865.24	$747.62	$173.05	$149.52
31546	Remove vc lesion scope/graft.				21.8010	$865.24	$747.62	$173.05	$149.52
31560	Laryngoscop w/ arytenoidectom.				21.8010	$865.24	$791.12	$173.05	$158.22
31561	Larynscop, remve cart + scop.				21.8010	$865.24	$791.12	$173.05	$158.22
31570	Laryngoscope w/vc inj.				15.1300	$600.48	$523.24	$120.10	$104.65
31571	Laryngoscop w/ vc inj + scope.				21.8010	$865.24	$655.62	$173.05	$131.12
31575	Diagnostic laryngoscopy.	Y	Y		1.4038	$55.71	$55.71	$11.14	$11.14
31576	Laryngoscopy with biopsy.				21.8010	$865.24	$655.62	$173.05	$131.12
31577	Remove foreign body, larynx.				3.8737	$153.74	$196.08	$30.75	$39.22
31578	Removal of larynx lesion.				21.8010	$865.24	$655.62	$173.05	$131.12
31579	Diagnostic laryngoscopy.	Y	Y	Y	2.8542	$113.28	$113.28	$22.66	$22.66
31580	Revision of larynx.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
31582	Revision of larynx.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
31588	Revision of larynx.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
31590	Reinnervate larynx.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
31595	Larynx nerve surgery.				37.7719	$1,499.09	$972.55	$299.82	$194.51
31603	Incision of windpipe.				7.7261	$306.63	$319.82	$61.33	$63.96
31605	Incision of windpipe.	Y			7.7261	$306.63	$306.63	$61.33	$61.33
31611	Surgery/speech prosthesis.				23.1564	$919.03	$714.52	$183.81	$142.90
31612	Puncture/clear windpipe.				23.1564	$919.03	$626.02	$183.81	$125.20
31613	Repair windpipe opening.				23.1564	$919.03	$682.52	$183.81	$136.50
31614	Repair windpipe opening.				37.7719	$1,499.09	$972.55	$299.82	$194.51
31615	Visualization of windpipe.				9.3905	$372.69	$352.85	$74.54	$70.57
31620	Endobronchial us add-on.	Y			29.7322	$1,180.01	$1,180.01	$236.00	$236.00
31622	Dx bronchoscope/wash.				9.3905	$372.69	$352.85	$74.54	$70.57
31623	Dx bronchoscope/brush.				9.3905	$372.69	$409.35	$74.54	$81.87
31624	Dx bronchoscope/lavage.				9.3905	$372.69	$409.35	$74.54	$81.87
31625	Bronchoscopy w/biopsy(s).				9.3905	$372.69	$409.35	$74.54	$81.87
31628	Bronchoscopy/lung bx, each.				9.3905	$372.69	$409.35	$74.54	$81.87
31629	Bronchoscopy/needle bx, each.				9.3905	$372.69	$409.35	$74.54	$81.87

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
31630	Bronchoscopy dilate/fx repr.				21.8803	$868.39	$657.19	$173.68	$131.44
31631	Bronchoscopy, dilate w/stent.				21.8803	$868.39	$657.19	$173.68	$131.44
31632	Bronchoscopy/ lung bx, add'l.	Y			9.3905	$372.69	$372.69	$74.54	$74.54
31633	Bronchoscopy/ needle bx add'l.	Y			9.3905	$372.69	$372.69	$74.54	$74.54
31635	Bronchoscopy w/fb removal.				9.3905	$372.69	$409.35	$74.54	$81.87
31636	Bronchoscopy, bronch stents.				21.8803	$868.39	$657.19	$173.68	$131.44
31637	Bronchoscopy, stent add-on.				9.3905	$372.69	$352.85	$74.54	$70.57
31638	Bronchoscopy, revise stent.				21.8803	$868.39	$657.19	$173.68	$131.44
31640	Bronchoscopy w/tumor excise.				21.8803	$868.39	$657.19	$173.68	$131.44
31641	Bronchoscopy, treat blockage.				21.8803	$868.39	$657.19	$173.68	$131.44
31643	Diag bronchoscope/catheter.				9.3905	$372.69	$409.35	$74.54	$81.87
31645	Bronchoscopy, clear airways.				9.3905	$372.69	$352.85	$74.54	$70.57
31646	Bronchoscopy, reclear airway.				9.3905	$372.69	$352.85	$74.54	$70.57
31656	Bronchoscopy, inj for x-ray.				9.3905	$372.69	$352.85	$74.54	$70.57
31700	Insertion of airway catheter.				1.4038	$55.71	$71.06	$11.14	$14.21
31717	Bronchial brush biopsy.				3.8737	$153.74	$196.08	$30.75	$39.22
31720	Clearance of airways.				0.7572	$30.05	$38.33	$6.01	$7.67
31730	Intro, windpipe wire/tube.				3.8737	$153.74	$196.08	$30.75	$39.22
31750	Repair of windpipe.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
31755	Repair of windpipe.				37.7719	$1,499.09	$972.55	$299.82	$194.51
31820	Closure of windpipe lesion.				16.4494	$652.85	$492.92	$130.57	$98.58
31825	Repair of windpipe defect.				23.1564	$919.03	$682.52	$183.81	$136.50
31830	Revise windpipe scar.				23.1564	$919.03	$682.52	$183.81	$136.50
32000	Drainage of chest.				3.6425	$144.56	$184.38	$28.91	$36.88
32002	Treatment of collapsed lung.	Y			3.6425	$144.56	$144.56	$28.91	$28.91
32019	Insert pleural catheter.	Y			29.2259	$1,159.92	$1,159.92	$231.98	$231.98
32020	Tube thoracostomy.	Y			3.6425	$144.56	$144.56	$28.91	$28.91
32400	Needle biopsy chest lining.				6.0729	$241.02	$287.01	$48.20	$57.40
32405	Biopsy, lung or mediastinum.				6.0729	$241.02	$287.01	$48.20	$57.40
32420	Puncture/clear lung.				3.6425	$144.56	$184.38	$28.91	$36.88
32960	Therapeutic pneumothorax.	Y			3.6425	$144.56	$144.56	$28.91	$28.91
33010	Drainage of heart sac.				3.6425	$144.56	$184.38	$28.91	$36.88

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
33011	Repeat drainage of heart sac.				3.6425	$144.56	$184.38	$28.91	$36.88
33206	Insertion of heart pacemaker.	Y			121.9402	$4,839.57	$4,839.57	$967.91	$967.91
33212	Insertion of pulse generator.				97.8357	$3,882.91	$2,196.46	$776.58	$439.29
33213	Insertion of pulse generator.				112.2347	$4,454.38	$2,482.19	$890.88	$496.44
33214	Upgrade of pacemaker system.	Y			153.1524	$6,078.33	$6,078.33	$1,215.67	$1,215.67
33215	Reposition pacing-defib lead.	Y			23.4666	$931.34	$931.34	$186.27	$186.27
33216	Insert lead pace-defib, one.	Y			44.7574	$1,776.34	$1,776.34	$355.27	$355.27
33217	Insert lead pace-defib, dual.	Y			44.7574	$1,776.34	$1,776.34	$355.27	$355.27
33218	Repair lead pace-defib, one.	Y			44.7574	$1,776.34	$1,776.34	$355.27	$355.27
33220	Repair lead pace-defib, dual.	Y			44.7574	$1,776.34	$1,776.34	$355.27	$355.27
33222	Revise pocket, pacemaker.				21.2645	$843.95	$644.97	$168.79	$128.99
33223	Revise pocket, pacing-defib.				21.2645	$843.95	$644.97	$168.79	$128.99
33224	Insert pacing lead & connect.	Y			267.8870	$10,631.92	$10,631.92	$2,126.38	$2,126.38
33225	L ventric pacing lead add-on.	Y			267.8870	$10,631.92	$10,631.92	$2,126.38	$2,126.38
33226	Reposition l ventric lead.	Y			23.4666	$931.34	$931.34	$186.27	$186.27
33233	Removal of pacemaker system.				23.4666	$931.34	$688.67	$186.27	$137.73
33234	Removal of pacemaker system.	Y			23.4666	$931.34	$931.34	$186.27	$186.27
33241	Remove pulse generator.	Y			23.4666	$931.34	$931.34	$186.27	$186.27
33282	Implant pat-active ht record.	Y			74.8877	$2,972.15	$2,972.15	$594.43	$594.43
33284	Remove pat-active ht record.	Y			10.9541	$434.75	$434.75	$86.95	$86.95
35188	Repair blood vessel lesion.				37.9652	$1,506.77	$1,068.38	$301.35	$213.68
35207	Repair blood vessel lesion.				37.9652	$1,506.77	$1,068.38	$301.35	$213.68
35473	Repair arterial blockage.	Y			42.8894	$1,702.20	$1,702.20	$340.44	$340.44
35474	Repair arterial blockage.	Y			42.8894	$1,702.20	$1,702.20	$340.44	$340.44
35476	Repair venous blockage.	Y			42.8894	$1,702.20	$1,702.20	$340.44	$340.44
35492	Atherectomy, percutaneous.	Y			42.8894	$1,702.20	$1,702.20	$340.44	$340.44
35761	Exploration of artery/vein.	Y			29.4757	$1,169.83	$1,169.83	$233.97	$233.97
35875	Removal of clot in graft.				37.9652	$1,506.77	$1,422.88	$301.35	$284.58

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
35876	Removal of clot in graft.				37.9652	$1,506.77	$1,422.88	$301.35	$284.58
36002	Pseudoaneurysm injection trt.	Y			2.5166	$99.88	$99.88	$19.98	$19.98
36260	Insertion of infusion pump.				28.4646	$1,129.71	$819.85	$225.94	$163.97
36261	Revision of infusion pump.				28.4646	$1,129.71	$787.85	$225.94	$157.57
36262	Removal of infusion pump.				22.6984	$900.86	$616.93	$180.17	$123.39
36420	Vein access cutdown < 1 yr.	Y			0.2016	$8.00	$8.00	$1.60	$1.60
36425	Vein access cutdown > 1 yr.	Y	Y	Y	0.1841	$7.31	$7.31	$1.46	$1.46
36430	Blood transfusion service.	Y	Y	Y	0.8269	$32.82	$32.82	$6.56	$6.56
36440	Bl push transfuse, 2 yr or.	Y	Y	Y	0.3133	$12.43	$12.43	$2.49	$2.49
36450	Bl exchange/transfuse, nb.	Y	Y		0.6213	$24.66	$24.66	$4.93	$4.93
36468	Injection(s), spider veins.	Y	Y		1.1035	$43.80	$43.80	$8.76	$8.76
36469	Injection(s), spider veins.	Y			1.1035	$43.80	$43.80	$8.76	$8.76
36470	Injection therapy of vein.	Y	Y		1.1035	$43.80	$43.80	$8.76	$8.76
36471	Injection therapy of veins.	Y	Y		1.1035	$43.80	$43.80	$8.76	$8.76
36475	Endovenous rf, 1st vein.				34.6279	$1,374.32	$942.16	$274.86	$188.43
36476	Endovenous rf, vein add-on.				34.6279	$1,374.32	$942.16	$274.86	$188.43
36478	Endovenous laser, 1st vein.				24.5817	$975.60	$742.80	$195.12	$148.56
36479	Endovenous laser vein addon.				24.5817	$975.60	$742.80	$195.12	$148.56
36511	Apheresis wbc	Y			11.7005	$464.37	$464.37	$92.87	$92.87
36512	Apheresis rbc	Y			11.7005	$464.37	$464.37	$92.87	$92.87
36513	Apheresis platelets.	Y			11.7005	$464.37	$464.37	$92.87	$92.87
36514	Apheresis plasma.	Y			11.7005	$464.37	$464.37	$92.87	$92.87
36515	Apheresis, adsorp/reinfuse.	Y			30.6602	$1,216.84	$1,216.84	$243.37	$243.37
36516	Apheresis, selective.	Y			30.6602	$1,216.84	$1,216.84	$243.37	$243.37
36522	Photopheresis	Y			30.6602	$1,216.84	$1,216.84	$243.37	$243.37
36550	Declot vascular device.	Y	Y	Y	0.5176	$20.54	$20.54	$4.11	$4.11
36555	Insert non-tunnel cv cath.				8.7841	$348.62	$340.81	$69.72	$68.16
36556	Insert non-tunnel cv cath.				8.7841	$348.62	$340.81	$69.72	$68.16
36557	Insert tunneled cv cath.				22.6984	$900.86	$673.43	$180.17	$134.69
36558	Insert tunneled cv cath.				22.6984	$900.86	$673.43	$180.17	$134.69
36560	Insert tunneled cv cath.				28.4646	$1,129.71	$819.85	$225.94	$163.97
36561	Insert tunneled cv cath.				28.4646	$1,129.71	$819.85	$225.94	$163.97
36563	Insert tunneled cv cath.				28.4646	$1,129.71	$819.85	$225.94	$163.97

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
36565	Insert tunneled cv cath.				28.4646	$1,129.71	$819.85	$225.94	$163.97
36566	Insert tunneled cv cath.				28.4646	$1,129.71	$819.85	$225.94	$163.97
36568	Insert picc cath				8.7841	$348.62	$340.81	$69.72	$68.16
36569	Insert picc cath				8.7841	$348.62	$340.81	$69.72	$68.16
36570	Insert picvad cath.				22.6984	$900.86	$705.43	$180.17	$141.09
36571	Insert picvad cath.				22.6984	$900.86	$705.43	$180.17	$141.09
36575	Repair tunneled cv cath.				8.7841	$348.62	$397.31	$69.72	$79.46
36576	Repair tunneled cv cath.				8.7841	$348.62	$397.31	$69.72	$79.46
36578	Replace tunneled cv cath.				22.6984	$900.86	$673.43	$180.17	$134.69
36580	Replace cvad cath.				8.7841	$348.62	$340.81	$69.72	$68.16
36581	Replace tunneled cv cath.				22.6984	$900.86	$673.43	$180.17	$134.69
36582	Replace tunneled cv cath.				28.4646	$1,129.71	$819.85	$225.94	$163.97
36583	Replace tunneled cv cath.				28.4646	$1,129.71	$819.85	$225.94	$163.97
36584	Replace picc cath.				8.7841	$348.62	$340.81	$69.72	$68.16
36585	Replace picvad cath.				22.6984	$900.86	$705.43	$180.17	$141.09
36589	Removal tunneled cv cath.				8.7841	$348.62	$340.81	$69.72	$68.16
36590	Removal tunneled cv cath.				8.7841	$348.62	$340.81	$69.72	$68.16
36595	Mech remov tunneled cv cath.	Y			22.6984	$900.86	$900.86	$180.17	$180.17
36596	Mech remov tunneled cv cath.	Y			8.7841	$348.62	$348.62	$69.72	$69.72
36598	Inj w/fluor, eval cv device.	Y	Y		0.6211	$24.65	$24.65	$4.93	$4.93
36640	Insertion catheter, artery.				28.4646	$1,129.71	$731.35	$225.94	$146.27
36680	Insert needle, bone cavity.	Y			1.0948	$43.45	$43.45	$8.69	$8.69
36800	Insertion of cannula.				29.4757	$1,169.83	$839.92	$233.97	$167.98
36810	Insertion of cannula.				29.4757	$1,169.83	$839.92	$233.97	$167.98
36815	Insertion of cannula.				29.4757	$1,169.83	$839.92	$233.97	$167.98
36818	Av fuse, uppr arm, cephalic.	Y			37.9652	$1,506.77	$1,506.77	$301.35	$301.35
36819	Av fuse, uppr arm, basilic.				37.9652	$1,506.77	$1,008.38	$301.35	$201.68
36820	Av fusion/forearm vein.				37.9652	$1,506.77	$1,008.38	$301.35	$201.68
36821	Av fusion direct any site.				37.9652	$1,506.77	$1,008.38	$301.35	$201.68
36825	Artery-vein autograft.				37.9652	$1,506.77	$1,068.38	$301.35	$213.68
36830	Artery-vein nonautograft.				37.9652	$1,506.77	$1,068.38	$301.35	$213.68
36831	Open thrombect av fistula.				37.9652	$1,506.77	$1,422.88	$301.35	$284.58
36832	Av fistula revision, open.				37.9652	$1,506.77	$1,068.38	$301.35	$213.68
36833	Av fistula revision.				37.9652	$1,506.77	$1,068.38	$301.35	$213.68

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
36834	Repair a-v aneurysm.				37.9652	$1,506.77	$1,008.38	$301.35	$201.68
36835	Artery to vein shunt.				29.4757	$1,169.83	$899.92	$233.97	$179.98
36860	External cannula declotting.				2.0612	$81.81	$104.34	$16.36	$20.87
36861	Cannula declotting.				29.4757	$1,169.83	$839.92	$233.97	$167.98
36870	Percut thrombect av fistula.				31.0004	$1,230.35	$1,284.67	$246.07	$256.93
37184	Prim art mech thrombectomy.	Y			31.0004	$1,230.35	$1,230.35	$246.07	$246.07
37185	Prim art m-thrombect add-on.	Y			17.0436	$676.43	$676.43	$135.29	$135.29
37186	Sec art m-thrombect add-on.	Y			17.0436	$676.43	$676.43	$135.29	$135.29
37187	Venous mech thrombectomy.	Y			31.0004	$1,230.35	$1,230.35	$246.07	$246.07
37188	Venous m-thrombectomy add-on.	Y			31.0004	$1,230.35	$1,230.35	$246.07	$246.07
37200	Transcatheter biopsy.	Y			6.0729	$241.02	$241.02	$48.20	$48.20
37203	Transcatheter retrieval.	Y			17.0436	$676.43	$676.43	$135.29	$135.29
37205	Transcath iv stent, percut.	Y			66.0804	$2,622.60	$2,622.60	$524.52	$524.52
37250	Iv us first vessel add-on.	Y			32.2182	$1,278.68	$1,278.68	$255.74	$255.74
37251	Iv us each add vessel add-on.	Y			32.2182	$1,278.68	$1,278.68	$255.74	$255.74
37500	Endoscopy ligate perf veins.				34.6279	$1,374.32	$942.16	$274.86	$188.43
37607	Ligation of a-v fistula.				24.5817	$975.60	$742.80	$195.12	$148.56
37609	Temporal artery procedure.				14.9563	$593.59	$519.79	$118.72	$103.96
37650	Revision of major vein.				24.5817	$975.60	$710.80	$195.12	$142.16
37700	Revise leg vein				34.6279	$1,374.32	$910.16	$274.86	$182.03
37718	Ligate/strip short leg vein.				34.6279	$1,374.32	$942.16	$274.86	$188.43
37722	Ligate/strip long leg vein.				34.6279	$1,374.32	$942.16	$274.86	$188.43
37735	Removal of leg veins/lesion.				34.6279	$1,374.32	$942.16	$274.86	$188.43
37760	Ligation, leg veins, open.				24.5817	$975.60	$742.80	$195.12	$148.56
37765	Phleb veins - extrem - to 20.	Y	Y	Y	3.5230	$139.82	$139.82	$27.96	$27.96
37766	Phleb veins - extrem 20+.	Y	Y	Y	4.0582	$161.06	$161.06	$32.21	$32.21
37780	Revision of leg vein.				24.5817	$975.60	$742.80	$195.12	$148.56
37785	Ligate/divide/excise vein.				24.5817	$975.60	$742.80	$195.12	$148.56
37790	Penile venous occlusion.				32.9991	$1,309.67	$909.84	$261.93	$181.97
38205	Harvest allogenic stem cells.	Y			11.7005	$464.37	$464.37	$92.87	$92.87
38206	Harvest auto stem cells.	Y			11.7005	$464.37	$464.37	$92.87	$92.87

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
38220	Bone marrow aspiration.	Y	Y		2.4295	$96.42	$96.42	$19.28	$19.28
38221	Bone marrow biopsy.	Y	Y		2.4295	$96.42	$96.42	$19.28	$19.28
38230	Bone marrow collection.	Y			23.2490	$922.71	$922.71	$184.54	$184.54
38241	Bone marrow/stem transplant.	Y			23.2490	$922.71	$922.71	$184.54	$184.54
38242	Lymphocyte infuse transplant.	Y	Y	Y	0.6143	$24.38	$24.38	$4.88	$4.88
38300	Drainage, lymph node lesion.				10.9184	$433.33	$383.17	$86.67	$76.63
38305	Drainage, lymph node lesion.				17.4686	$693.30	$569.65	$138.66	$113.93
38308	Incision of lymph channels.				21.3673	$848.03	$647.01	$169.61	$129.40
38500	Biopsy/removal, lymph nodes.				21.3673	$848.03	$647.01	$169.61	$129.40
38505	Needle biopsy, lymph nodes.				3.8051	$151.02	$192.61	$30.20	$38.52
38510	Biopsy/removal, lymph nodes.				21.3673	$848.03	$647.01	$169.61	$129.40
38520	Biopsy/removal, lymph nodes.				21.3673	$848.03	$647.01	$169.61	$129.40
38525	Biopsy/removal, lymph nodes.				21.3673	$848.03	$647.01	$169.61	$129.40
38530	Biopsy/removal, lymph nodes.				21.3673	$848.03	$647.01	$169.61	$129.40
38542	Explore deep node(s), neck.				37.1283	$1,473.55	$959.78	$294.71	$191.96
38550	Removal, neck/armpit lesion.				21.3673	$848.03	$679.01	$169.61	$135.80
38555	Removal, neck/armpit lesion.				21.3673	$848.03	$739.01	$169.61	$147.80
38570	Laparoscopy, lymph node biop.				43.5124	$1,726.92	$1,532.96	$345.38	$306.59
38571	Laparoscopy, lymphadenectomy.				70.8854	$2,813.31	$2,076.15	$562.66	$415.23
38572	Laparoscopy, lymphadenectomy.				43.5124	$1,726.92	$1,532.96	$345.38	$306.59
38700	Removal of lymph nodes, neck.	Y			21.3673	$848.03	$848.03	$169.61	$169.61
38740	Remove armpit lymph nodes.				37.1283	$1,473.55	$959.78	$294.71	$191.96
38745	Remove armpit lymph nodes.				37.1283	$1,473.55	$1,051.78	$294.71	$210.36
38760	Remove groin lymph nodes.				21.3673	$848.03	$647.01	$169.61	$129.40
40490	Biopsy of lip	Y	Y	Y	1.6094	$63.87	$63.87	$12.77	$12.77
40500	Partial excision of lip.				16.4494	$652.85	$549.42	$130.57	$109.88
40510	Partial excision of lip.				23.1564	$919.03	$682.52	$183.81	$136.50
40520	Partial excision of lip.				16.4494	$652.85	$549.42	$130.57	$109.88
40525	Reconstruct lip with flap.				23.1564	$919.03	$682.52	$183.81	$136.50
40527	Reconstruct lip with flap.				23.1564	$919.03	$682.52	$183.81	$136.50
40530	Partial removal of lip.				23.1564	$919.03	$682.52	$183.81	$136.50

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
40650	Repair lip				7.7261	$306.63	$391.09	$61.33	$78.22
40652	Repair lip				7.7261	$306.63	$391.09	$61.33	$78.22
40654	Repair lip				7.7261	$306.63	$391.09	$61.33	$78.22
40700	Repair cleft lip/nasal.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
40701	Repair cleft lip/nasal.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
40702	Repair cleft lip/nasal.	Y	Y	Y	6.6019	$262.02	$262.02	$52.40	$52.40
40720	Repair cleft lip/nasal.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
40761	Repair cleft lip/nasal.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
40800	Drainage of mouth lesion.	Y	Y		1.4821	$58.82	$58.82	$11.76	$11.76
40801	Drainage of mouth lesion.				7.7261	$306.63	$376.32	$61.33	$75.26
40804	Removal, foreign body, mouth.	Y	Y		0.6211	$24.65	$24.65	$4.93	$4.93
40805	Removal, foreign body, mouth.	Y	Y	Y	4.1994	$166.66	$166.66	$33.33	$33.33
40806	Incision of lip fold.	Y	Y	Y	1.8622	$73.91	$73.91	$14.78	$14.78
40808	Biopsy of mouth lesion.	Y	Y		2.3768	$94.33	$94.33	$18.87	$18.87
40810	Excision of mouth lesion.	Y	Y	Y	2.8430	$112.83	$112.83	$22.57	$22.57
40812	Excise/repair mouth lesion.	Y	Y	Y	3.6275	$143.97	$143.97	$28.79	$28.79
40814	Excise/repair mouth lesion.				16.4494	$652.85	$549.42	$130.57	$109.88
40816	Excision of mouth lesion.				23.1564	$919.03	$682.52	$183.81	$136.50
40818	Excise oral mucosa for graft.				2.3768	$94.33	$120.31	$18.87	$24.06
40819	Excise lip or cheek fold.				7.7261	$306.63	$319.82	$61.33	$63.96
40820	Treatment of mouth lesion.	Y	Y	Y	3.9656	$157.39	$157.39	$31.48	$31.48
40830	Repair mouth laceration.	Y			2.3768	$94.33	$94.33	$18.87	$18.87
40831	Repair mouth laceration.				7.7261	$306.63	$319.82	$61.33	$63.96
40840	Reconstruction of mouth.				23.1564	$919.03	$682.52	$183.81	$136.50
40842	Reconstruction of mouth.				23.1564	$919.03	$714.52	$183.81	$142.90
40843	Reconstruction of mouth.				23.1564	$919.03	$714.52	$183.81	$142.90
40844	Reconstruction of mouth.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
40845	Reconstruction of mouth.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
41000	Drainage of mouth lesion.	Y	Y	Y	2.1048	$83.53	$83.53	$16.71	$16.71
41005	Drainage of mouth lesion.				2.3768	$94.33	$120.31	$18.87	$24.06
41006	Drainage of mouth lesion.				23.1564	$919.03	$626.02	$183.81	$125.20
41007	Drainage of mouth lesion.				16.4494	$652.85	$492.92	$130.57	$98.58
41008	Drainage of mouth lesion.				16.4494	$652.85	$492.92	$130.57	$98.58
41009	Drainage of mouth lesion.				2.3768	$94.33	$120.31	$18.87	$24.06

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
41010	Incision of tongue fold.				7.7261	$306.63	$319.82	$61.33	$63.96
41015	Drainage of mouth lesion.				2.3768	$94.33	$120.31	$18.87	$24.06
41016	Drainage of mouth lesion.				7.7261	$306.63	$319.82	$61.33	$63.96
41017	Drainage of mouth lesion.				7.7261	$306.63	$319.82	$61.33	$63.96
41018	Drainage of mouth lesion.				7.7261	$306.63	$319.82	$61.33	$63.96
41100	Biopsy of tongue.	Y	Y	Y	2.1907	$86.95	$86.95	$17.39	$17.39
41105	Biopsy of tongue.	Y	Y	Y	2.1418	$85.00	$85.00	$17.00	$17.00
41108	Biopsy of floor of mouth.	Y	Y	Y	1.9697	$78.17	$78.17	$15.63	$15.63
41110	Excision of tongue lesion.	Y	Y	Y	2.8336	$112.46	$112.46	$22.49	$22.49
41112	Excision of tongue lesion.				16.4494	$652.85	$549.42	$130.57	$109.88
41113	Excision of tongue lesion.				16.4494	$652.85	$549.42	$130.57	$109.88
41114	Excision of tongue lesion.				23.1564	$919.03	$682.52	$183.81	$136.50
41115	Excision of tongue fold.	Y	Y	Y	3.3338	$132.31	$132.31	$26.46	$26.46
41116	Excision of mouth lesion.				16.4494	$652.85	$492.92	$130.57	$98.58
41120	Partial removal of tongue.				23.1564	$919.03	$818.02	$183.81	$163.60
41250	Repair tongue laceration.				2.3768	$94.33	$120.31	$18.87	$24.06
41251	Repair tongue laceration.				2.3768	$94.33	$120.31	$18.87	$24.06
41252	Repair tongue laceration.				7.7261	$306.63	$376.32	$61.33	$75.26
41500	Fixation of tongue.				23.1564	$919.03	$626.02	$183.81	$125.20
41510	Tongue to lip surgery.				16.4494	$652.85	$492.92	$130.57	$98.58
41520	Reconstruction, tongue fold.				7.7261	$306.63	$376.32	$61.33	$75.26
41800	Drainage of gum lesion.				1.4821	$58.82	$75.02	$11.76	$15.00
41805	Removal foreign body, gum.	Y	Y	Y	3.2618	$129.45	$129.45	$25.89	$25.89
41806	Removal foreign body,jawbone.	Y	Y	Y	4.1774	$165.79	$165.79	$33.16	$33.16
41820	Excision, gum, each quadrant.	Y	Y		7.7261	$306.63	$306.63	$61.33	$61.33
41821	Excision of gum flap.	Y			7.7261	$306.63	$306.63	$61.33	$61.33
41822	Excision of gum lesion.	Y	Y	Y	3.7793	$149.99	$149.99	$30.00	$30.00
41823	Excision of gum lesion.	Y	Y	Y	5.3407	$211.96	$211.96	$42.39	$42.39
41825	Excision of gum lesion.	Y	Y	Y	2.9473	$116.97	$116.97	$23.39	$23.39
41826	Excision of gum lesion.	Y	Y	Y	3.3501	$132.96	$132.96	$26.59	$26.59
41827	Excision of gum lesion.				23.1564	$919.03	$682.52	$183.81	$136.50
41828	Excision of gum lesion.	Y	Y	Y	3.4999	$138.90	$138.90	$27.78	$27.78
41830	Removal of gum tissue.	Y	Y	Y	4.8590	$192.84	$192.84	$38.57	$38.57

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
41850	Treatment of gum lesion.	Y	Y		16.4494	$652.85	$652.85	$130.57	$130.57
41870	Gum graft	Y			23.1564	$919.03	$919.03	$183.81	$183.81
41872	Repair gum	Y	Y	Y	1.6239	$64.45	$64.45	$12.89	$12.89
41874	Repair tooth socket.	Y	Y	Y	4.6763	$185.59	$185.59	$37.12	$37.12
42000	Drainage mouth roof lesion.				2.3768	$94.33	$120.31	$18.87	$24.06
42100	Biopsy roof of mouth.	Y	Y	Y	1.8757	$74.44	$74.44	$14.89	$14.89
42104	Excision lesion, mouth roof.	Y	Y	Y	2.6328	$104.49	$104.49	$20.90	$20.90
42106	Excision lesion, mouth roof.	Y	Y	Y	3.3670	$133.63	$133.63	$26.73	$26.73
42107	Excision lesion, mouth roof.				23.1564	$919.03	$682.52	$183.81	$136.50
42120	Remove palate/lesion.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
42140	Excision of uvula.				7.7261	$306.63	$376.32	$61.33	$75.26
42145	Repair palate, pharynx/uvula.				23.1564	$919.03	$818.02	$183.81	$163.60
42160	Treatment mouth roof lesion.	Y	Y	Y	3.4534	$137.06	$137.06	$27.41	$27.41
42180	Repair palate				2.3768	$94.33	$120.31	$18.87	$24.06
42182	Repair palate				37.7719	$1,499.09	$972.55	$299.82	$194.51
42200	Reconstruct cleft palate.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
42205	Reconstruct cleft palate.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
42210	Reconstruct cleft palate.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
42215	Reconstruct cleft palate.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
42220	Reconstruct cleft palate.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
42226	Lengthening of palate.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
42235	Repair palate				16.4494	$652.85	$684.92	$130.57	$136.98
42260	Repair nose to lip fistula.				23.1564	$919.03	$774.52	$183.81	$154.90
42280	Preparation, palate mold.	Y	Y	Y	1.8635	$73.96	$73.96	$14.79	$14.79
42281	Insertion, palate prosthesis.	Y			16.4494	$652.85	$652.85	$130.57	$130.57
42300	Drainage of salivary gland.				16.4494	$652.85	$492.92	$130.57	$98.58
42305	Drainage of salivary gland.				16.4494	$652.85	$549.42	$130.57	$109.88
42310	Drainage of salivary gland.				2.3768	$94.33	$120.31	$18.87	$24.06
42320	Drainage of salivary gland.				2.3768	$94.33	$120.31	$18.87	$24.06
42330	Removal of salivary stone.	Y	Y	Y	2.7864	$110.59	$110.59	$22.12	$22.12
42335	Removal of salivary stone.	Y	Y	Y	4.5522	$180.67	$180.67	$36.13	$36.13
42340	Removal of salivary stone.				16.4494	$652.85	$549.42	$130.57	$109.88
42400	Biopsy of salivary gland.	Y	Y	Y	1.5674	$62.21	$62.21	$12.44	$12.44
42405	Biopsy of salivary gland.				16.4494	$652.85	$549.42	$130.57	$109.88
42408	Excision of salivary cyst.				16.4494	$652.85	$581.42	$130.57	$116.28
42409	Drainage of salivary cyst.				16.4494	$652.85	$581.42	$130.57	$116.28

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
42410	Excise parotid gland/lesion.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
42415	Excise parotid gland/lesion.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
42420	Excise parotid gland/lesion.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
42425	Excise parotid gland/lesion.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
42440	Excise submaxillary gland.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
42450	Excise sublingual gland.				23.1564	$919.03	$682.52	$183.81	$136.50
42500	Repair salivary duct.				23.1564	$919.03	$714.52	$183.81	$142.90
42505	Repair salivary duct.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
42507	Parotid duct diversion.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
42508	Parotid duct diversion.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
42509	Parotid duct diversion.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
42510	Parotid duct diversion.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
42600	Closure of salivary fistula.				16.4494	$652.85	$492.92	$130.57	$98.58
42650	Dilation of salivary duct.	Y	Y	Y	1.0121	$40.17	$40.17	$8.03	$8.03
42660	Dilation of salivary duct.	Y	Y	Y	1.2294	$48.79	$48.79	$9.76	$9.76
42665	Ligation of salivary duct.				23.1564	$919.03	$957.02	$183.81	$191.40
42700	Drainage of tonsil abscess.				2.3768	$94.33	$120.31	$18.87	$24.06
42720	Drainage of throat abscess.				16.4494	$652.85	$492.92	$130.57	$98.58
42725	Drainage of throat abscess.				37.7719	$1,499.09	$972.55	$299.82	$194.51
42800	Biopsy of throat	Y	Y	Y	1.9620	$77.87	$77.87	$15.57	$15.57
42802	Biopsy of throat				16.4494	$652.85	$492.92	$130.57	$98.58
42804	Biopsy of upper nose/throat.				16.4494	$652.85	$492.92	$130.57	$98.58
42806	Biopsy of upper nose/throat.				23.1564	$919.03	$682.52	$183.81	$136.50
42808	Excise pharynx lesion.				16.4494	$652.85	$549.42	$130.57	$109.88
42809	Remove pharynx foreign body.	Y			0.6211	$24.65	$24.65	$4.93	$4.93
42810	Excision of neck cyst.				23.1564	$919.03	$714.52	$183.81	$142.90
42815	Excision of neck cyst.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
42820	Remove tonsils and adenoids.				22.7757	$903.92	$706.96	$180.78	$141.39
42821	Remove tonsils and adenoids.				22.7757	$903.92	$810.46	$180.78	$162.09
42825	Removal of tonsils.				22.7757	$903.92	$766.96	$180.78	$153.39
42826	Removal of tonsils.				22.7757	$903.92	$766.96	$180.78	$153.39
42830	Removal of adenoids.				22.7757	$903.92	$766.96	$180.78	$153.39
42831	Removal of adenoids.				22.7757	$903.92	$766.96	$180.78	$153.39

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
42835	Removal of adenoids.				22.7757	$903.92	$766.96	$180.78	$153.39
42836	Removal of adenoids.				22.7757	$903.92	$766.96	$180.78	$153.39
42860	Excision of tonsil tags.				22.7757	$903.92	$706.96	$180.78	$141.39
42870	Excision of lingual tonsil.				22.7757	$903.92	$706.96	$180.78	$141.39
42890	Partial removal of pharynx.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
42892	Revision of pharyngeal walls.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
42900	Repair throat wound.				7.7261	$306.63	$319.82	$61.33	$63.96
42950	Reconstruction of throat.				23.1564	$919.03	$682.52	$183.81	$136.50
42955	Surgical opening of throat.				23.1564	$919.03	$682.52	$183.81	$136.50
42960	Control throat bleeding.				1.2021	$47.71	$60.85	$9.54	$12.17
42962	Control throat bleeding.				37.7719	$1,499.09	$972.55	$299.82	$194.51
42970	Control nose/throat bleeding.	Y	Y		1.2021	$47.71	$47.71	$9.54	$9.54
42972	Control nose/throat bleeding.				16.4494	$652.85	$581.42	$130.57	$116.28
43030	Throat muscle surgery.	Y			16.4494	$652.85	$652.85	$130.57	$130.57
43200	Esophagus endoscopy.				8.3070	$329.69	$331.34	$65.94	$66.27
43201	Esoph scope w/submucous inj.				8.3070	$329.69	$331.34	$65.94	$66.27
43202	Esophagus endoscopy, biopsy.				8.3070	$329.69	$331.34	$65.94	$66.27
43204	Esoph scope w/sclerosis inj.				8.3070	$329.69	$331.34	$65.94	$66.27
43205	Esophagus endoscopy/ligation.				8.3070	$329.69	$331.34	$65.94	$66.27
43215	Esophagus endoscopy.				8.3070	$329.69	$331.34	$65.94	$66.27
43216	Esophagus endoscopy/lesion.				8.3070	$329.69	$331.34	$65.94	$66.27
43217	Esophagus endoscopy.				8.3070	$329.69	$331.34	$65.94	$66.27
43219	Esophagus endoscopy.				22.6777	$900.03	$616.52	$180.01	$123.30
43220	Esoph endoscopy, dilation.				8.3070	$329.69	$331.34	$65.94	$66.27
43226	Esoph endoscopy, dilation.				8.3070	$329.69	$331.34	$65.94	$66.27
43227	Esoph endoscopy, repair.				8.3070	$329.69	$387.84	$65.94	$77.57
43228	Esoph endoscopy, ablation.				27.5493	$1,093.38	$769.69	$218.68	$153.94
43231	Esoph endoscopy w/us exam.				8.3070	$329.69	$387.84	$65.94	$77.57
43232	Esoph endoscopy w/us fn bx.				8.3070	$329.69	$387.84	$65.94	$77.57
43234	Upper gi endoscopy, exam.				8.3070	$329.69	$331.34	$65.94	$66.27

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
43235	Uppr gi endoscopy, diagnosis.				8.3070	$329.69	$331.34	$65.94	$66.27
43236	Uppr gi scope w/submuc inj.				8.3070	$329.69	$387.84	$65.94	$77.57
43237	Endoscopic us exam, esoph.				8.3070	$329.69	$387.84	$65.94	$77.57
43238	Uppr gi endoscopy w/us fn bx.				8.3070	$329.69	$387.84	$65.94	$77.57
43239	Upper gi endoscopy, biopsy.				8.3070	$329.69	$387.84	$65.94	$77.57
43240	Esoph endoscope w/drain cyst.				8.3070	$329.69	$387.84	$65.94	$77.57
43241	Upper gi endoscopy with tube.				8.3070	$329.69	$387.84	$65.94	$77.57
43242	Uppr gi endoscopy w/us fn bx.				8.3070	$329.69	$387.84	$65.94	$77.57
43243	Upper gi endoscopy & inject.				8.3070	$329.69	$387.84	$65.94	$77.57
43244	Upper gi endoscopy/ligation.				8.3070	$329.69	$387.84	$65.94	$77.57
43245	Uppr gi scope dilate strictr.				8.3070	$329.69	$387.84	$65.94	$77.57
43246	Place gastrostomy tube.				8.3070	$329.69	$387.84	$65.94	$77.57
43247	Operative upper gi endoscopy.				8.3070	$329.69	$387.84	$65.94	$77.57
43248	Uppr gi endoscopy/guide wire.				8.3070	$329.69	$387.84	$65.94	$77.57
43249	Esoph endoscopy, dilation.				8.3070	$329.69	$387.84	$65.94	$77.57
43250	Upper gi endoscopy/tumor.				8.3070	$329.69	$387.84	$65.94	$77.57
43251	Operative upper gi endoscopy.				8.3070	$329.69	$387.84	$65.94	$77.57
43255	Operative upper gi endoscopy.				8.3070	$329.69	$387.84	$65.94	$77.57
43256	Uppr gi endoscopy w/stent.				22.6777	$900.03	$705.02	$180.01	$141.00
43257	Uppr gi scope w/thrml txmnt.	Y			27.5493	$1,093.38	$1,093.38	$218.68	$218.68
43258	Operative upper gi endoscopy.				8.3070	$329.69	$419.84	$65.94	$83.97
43259	Endoscopic ultrasound exam.				8.3070	$329.69	$419.84	$65.94	$83.97
43260	Endo cholangiopancreatograph.				19.8125	$786.32	$616.16	$157.26	$123.23
43261	Endo cholangiopancreatograph.				19.8125	$786.32	$616.16	$157.26	$123.23
43262	Endo cholangiopancreatograph.				19.8125	$786.32	$616.16	$157.26	$123.23
43263	Endo cholangiopancreatograph.				19.8125	$786.32	$616.16	$157.26	$123.23
43264	Endo cholangiopancreatograph.				19.8125	$786.32	$616.16	$157.26	$123.23

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
43265	Endo cholangiopancreatograph.				19.8125	$786.32	$616.16	$157.26	$123.23
43267	Endo cholangiopancreatograph.				19.8125	$786.32	$616.16	$157.26	$123.23
43268	Endo cholangiopancreatograph.				22.6777	$900.03	$673.02	$180.01	$134.60
43269	Endo cholangiopancreatograph.				22.6777	$900.03	$673.02	$180.01	$134.60
43271	Endo cholangiopancreatograph.				19.8125	$786.32	$616.16	$157.26	$123.23
43272	Endo cholangiopancreatograph.				19.8125	$786.32	$616.16	$157.26	$123.23
43450	Dilate esophagus.				5.3134	$210.88	$268.96	$42.18	$53.79
43453	Dilate esophagus.				5.3134	$210.88	$268.96	$42.18	$53.79
43456	Dilate esophagus.				5.3134	$210.88	$268.96	$42.18	$53.79
43458	Dilate esophagus.				5.3134	$210.88	$268.96	$42.18	$53.79
43600	Biopsy of stomach.				8.3070	$329.69	$331.34	$65.94	$66.27
43653	Laparoscopy, gastrostomy.				43.5124	$1,726.92	$1,532.96	$345.38	$306.59
43750	Place gastrostomy tube.				8.3070	$329.69	$387.84	$65.94	$77.57
43760	Change gastrostomy tube.				2.3431	$92.99	$118.61	$18.60	$23.72
43761	Reposition gastrostomy tube.	Y			7.2859	$289.16	$289.16	$57.83	$57.83
43870	Repair stomach opening.				8.3070	$329.69	$331.34	$65.94	$66.27
43886	Revise gastric port, open.	Y			5.0931	$202.14	$202.14	$40.43	$40.43
43887	Remove gastric port, open.	Y			5.0931	$202.14	$202.14	$40.43	$40.43
43888	Change gastric port, open.	Y			13.3433	$529.57	$529.57	$105.91	$105.91
44100	Biopsy of bowel				8.3070	$329.69	$331.34	$65.94	$66.27
44312	Revision of ileostomy.				21.2645	$843.95	$588.47	$168.79	$117.69
44340	Revision of colostomy.				21.2645	$843.95	$676.97	$168.79	$135.39
44360	Small bowel endoscopy.				9.3878	$372.58	$409.29	$74.52	$81.86
44361	Small bowel endoscopy/biopsy.				9.3878	$372.58	$409.29	$74.52	$81.86
44363	Small bowel endoscopy.				9.3878	$372.58	$409.29	$74.52	$81.86
44364	Small bowel endoscopy.				9.3878	$372.58	$409.29	$74.52	$81.86
44365	Small bowel endoscopy.				9.3878	$372.58	$409.29	$74.52	$81.86
44366	Small bowel endoscopy.				9.3878	$372.58	$409.29	$74.52	$81.86
44369	Small bowel endoscopy.				9.3878	$372.58	$409.29	$74.52	$81.86
44370	Small bowel endoscopy/stent.				22.6777	$900.03	$1,119.52	$180.01	$223.90
44372	Small bowel endoscopy.				9.3878	$372.58	$409.29	$74.52	$81.86

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
44373	Small bowel endoscopy.				9.3878	$372.58	$409.29	$74.52	$81.86
44376	Small bowel endoscopy.				9.3878	$372.58	$409.29	$74.52	$81.86
44377	Small bowel endoscopy/biopsy.				9.3878	$372.58	$409.29	$74.52	$81.86
44378	Small bowel endoscopy.				9.3878	$372.58	$409.29	$74.52	$81.86
44379	Sbowel endoscope w/stent.				22.6777	$900.03	$1,119.52	$180.01	$223.90
44380	Small bowel endoscopy.				9.3878	$372.58	$352.79	$74.52	$70.56
44382	Small bowel endoscopy.				9.3878	$372.58	$352.79	$74.52	$70.56
44383	Ileoscopy w/stent.				22.6777	$900.03	$1,119.52	$180.01	$223.90
44385	Endoscopy of bowel pouch.				8.8143	$349.82	$341.41	$69.96	$68.28
44386	Endoscopy, bowel pouch/biop.				8.8143	$349.82	$341.41	$69.96	$68.28
44388	Colonoscopy				8.8143	$349.82	$341.41	$69.96	$68.28
44389	Colonoscopy with biopsy.				8.8143	$349.82	$341.41	$69.96	$68.28
44390	Colonoscopy for foreign body.				8.8143	$349.82	$341.41	$69.96	$68.28
44391	Colonoscopy for bleeding.				8.8143	$349.82	$341.41	$69.96	$68.28
44392	Colonoscopy & polypectomy.				8.8143	$349.82	$341.41	$69.96	$68.28
44393	Colonoscopy, lesion removal.				8.8143	$349.82	$341.41	$69.96	$68.28
44394	Colonoscopy w/snare.				8.8143	$349.82	$341.41	$69.96	$68.28
44397	Colonoscopy w/stent.				22.6777	$900.03	$616.52	$180.01	$123.30
45000	Drainage of pelvic abscess.				4.8970	$194.35	$247.89	$38.87	$49.58
45005	Drainage of rectal abscess.				12.8778	$511.10	$478.55	$102.22	$95.71
45020	Drainage of rectal abscess.				12.8778	$511.10	$478.55	$102.22	$95.71
45100	Biopsy of rectum.				22.2336	$882.41	$607.70	$176.48	$121.54
45108	Removal of anorectal lesion.				22.2336	$882.41	$664.20	$176.48	$132.84
45150	Excision of rectal stricture.				22.2336	$882.41	$664.20	$176.48	$132.84
45160	Excision of rectal lesion.				22.2336	$882.41	$664.20	$176.48	$132.84
45170	Excision of rectal lesion.				22.2336	$882.41	$664.20	$176.48	$132.84
45190	Destruction, rectal tumor.				22.2336	$882.41	$1,110.70	$176.48	$222.14
45300	Proctosigmoidoscopy dx.	Y	Y	Y	1.5109	$59.96	$59.96	$11.99	$11.99
45303	Proctosigmoidoscopy dilate.	Y	Y		8.5644	$339.90	$339.90	$67.98	$67.98
45305	Proctosigmoidoscopy w/bx.				8.5644	$339.90	$336.45	$67.98	$67.29
45307	Proctosigmoidoscopy fb.				20.4902	$813.22	$573.11	$162.64	$114.62
45308	Proctosigmoidoscopy removal.				8.5644	$339.90	$336.45	$67.98	$67.29

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
45309	Proctosigmoidoscopy removal.				8.5644	$339.90	$336.45	$67.98	$67.29
45315	Proctosigmoidoscopy removal.				8.5644	$339.90	$336.45	$67.98	$67.29
45317	Proctosigmoidoscopy bleed.				8.5644	$339.90	$336.45	$67.98	$67.29
45320	Proctosigmoidoscopy ablate.				20.4902	$813.22	$573.11	$162.64	$114.62
45321	Proctosigmoidoscopy volvul.				20.4902	$813.22	$573.11	$162.64	$114.62
45327	Proctosigmoidoscopy w/stent.				22.6777	$900.03	$616.52	$180.01	$123.30
45330	Diagnostic sigmoidoscopy.	Y	Y	Y	2.0624	$81.85	$81.85	$16.37	$16.37
45331	Sigmoidoscopy and biopsy.				4.8005	$190.52	$243.00	$38.10	$48.60
45332	Sigmoidoscopy w/fb removal.				4.8005	$190.52	$243.00	$38.10	$48.60
45333	Sigmoidoscopy & polypectomy.				8.5644	$339.90	$336.45	$67.98	$67.29
45334	Sigmoidoscopy for bleeding.				8.5644	$339.90	$336.45	$67.98	$67.29
45335	Sigmoidoscopy w/submuc inj.				4.8005	$190.52	$243.00	$38.10	$48.60
45337	Sigmoidoscopy & decompress.				4.8005	$190.52	$243.00	$38.10	$48.60
45338	Sigmoidoscopy w/tumr remove.				8.5644	$339.90	$336.45	$67.98	$67.29
45339	Sigmoidoscopy w/ablate tumr.				8.5644	$339.90	$336.45	$67.98	$67.29
45340	Sig w/balloon dilation.				8.5644	$339.90	$336.45	$67.98	$67.29
45341	Sigmoidoscopy w/ultrasound.				8.5644	$339.90	$336.45	$67.98	$67.29
45342	Sigmoidoscopy w/us guide bx.				8.5644	$339.90	$336.45	$67.98	$67.29
45345	Sigmoidoscopy w/stent.				22.6777	$900.03	$616.52	$180.01	$123.30
45355	Surgical colonoscopy.				8.8143	$349.82	$341.41	$69.96	$68.28
45378	Diagnostic colonoscopy.				8.8143	$349.82	$397.91	$69.96	$79.58
45379	Colonoscopy w/fb removal.				8.8143	$349.82	$397.91	$69.96	$79.58
45380	Colonoscopy and biopsy.				8.8143	$349.82	$397.91	$69.96	$79.58
45381	Colonoscopy, submucous inj.				8.8143	$349.82	$397.91	$69.96	$79.58
45382	Colonoscopy/control bleeding.				8.8143	$349.82	$397.91	$69.96	$79.58
45383	Lesion removal colonoscopy.				8.8143	$349.82	$397.91	$69.96	$79.58
45384	Lesion remove colonoscopy.				8.8143	$349.82	$397.91	$69.96	$79.58
45385	Lesion removal colonoscopy.				8.8143	$349.82	$397.91	$69.96	$79.58
45386	Colonoscopy dilate stricture.				8.8143	$349.82	$397.91	$69.96	$79.58
45387	Colonoscopy w/stent.				22.6777	$900.03	$616.52	$180.01	$123.30

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
45391	Colonoscopy w/ endoscope us.				8.8143	$349.82	$397.91	$69.96	$79.58
45392	Colonoscopy w/ endoscopic fnb.				8.8143	$349.82	$397.91	$69.96	$79.58
45500	Repair of rectum.				22.2336	$882.41	$664.20	$176.48	$132.84
45505	Repair of rectum.				29.4386	$1,168.36	$807.18	$233.67	$161.44
45520	Treatment of rectal prolapse.	Y	Y		1.1035	$43.80	$43.80	$8.76	$8.76
45560	Repair of rectocele.				29.4386	$1,168.36	$807.18	$233.67	$161.44
45900	Reduction of rectal prolapse.				4.8970	$194.35	$247.89	$38.87	$49.58
45905	Dilation of anal sphincter.				22.2336	$882.41	$607.70	$176.48	$121.54
45910	Dilation of rectal narrowing.				22.2336	$882.41	$607.70	$176.48	$121.54
45915	Remove rectal obstruction.				4.8970	$194.35	$247.89	$38.87	$49.58
45990	Surg dx exam, anorectal.				4.8970	$194.35	$247.89	$38.87	$49.58
46020	Placement of seton.				22.2336	$882.41	$696.20	$176.48	$139.24
46030	Removal of rectal marker.				4.8970	$194.35	$247.89	$38.87	$49.58
46040	Incision of rectal abscess.				22.2336	$882.41	$696.20	$176.48	$139.24
46045	Incision of rectal abscess.				22.2336	$882.41	$664.20	$176.48	$132.84
46050	Incision of anal abscess.				4.8970	$194.35	$247.89	$38.87	$49.58
46060	Incision of rectal abscess.				22.2336	$882.41	$664.20	$176.48	$132.84
46070	Incision of anal septum.	Y			12.8778	$511.10	$511.10	$102.22	$102.22
46080	Incision of anal sphincter.				22.2336	$882.41	$696.20	$176.48	$139.24
46083	Incise external hemorrhoid.	Y	Y	Y	2.0708	$82.18	$82.18	$16.44	$16.44
46200	Removal of anal fissure.				22.2336	$882.41	$664.20	$176.48	$132.84
46210	Removal of anal crypt.				22.2336	$882.41	$664.20	$176.48	$132.84
46211	Removal of anal crypts.				22.2336	$882.41	$664.20	$176.48	$132.84
46220	Removal of anal tag.				22.2336	$882.41	$607.70	$176.48	$121.54
46221	Ligation of hemorrhoid(s).	Y	Y	Y	2.7306	$108.37	$108.37	$21.67	$21.67
46230	Removal of anal tags.				22.2336	$882.41	$607.70	$176.48	$121.54
46250	Hemorrhoidectomy.				22.2336	$882.41	$696.20	$176.48	$139.24
46255	Hemorrhoidectomy.				22.2336	$882.41	$696.20	$176.48	$139.24
46257	Remove hemorrhoids & fissure.				22.2336	$882.41	$696.20	$176.48	$139.24
46258	Remove hemorrhoids & fistula.				22.2336	$882.41	$696.20	$176.48	$139.24
46260	Hemorrhoidectomy.				22.2336	$882.41	$696.20	$176.48	$139.24

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
46261	Remove hemorrhoids & fissure.				22.2336	$882.41	$756.20	$176.48	$151.24
46262	Remove hemorrhoids & fistula.				22.2336	$882.41	$756.20	$176.48	$151.24
46270	Removal of anal fistula.				22.2336	$882.41	$696.20	$176.48	$139.24
46275	Removal of anal fistula.				22.2336	$882.41	$696.20	$176.48	$139.24
46280	Removal of anal fistula.				22.2336	$882.41	$756.20	$176.48	$151.24
46285	Removal of anal fistula.				22.2336	$882.41	$607.70	$176.48	$121.54
46288	Repair anal fistula.				22.2336	$882.41	$756.20	$176.48	$151.24
46320	Removal of hemorrhoid clot.	Y	Y	Y	1.9331	$76.72	$76.72	$15.34	$15.34
46500	Injection into hemorrhoid(s).	Y	Y	Y	2.4529	$97.35	$97.35	$19.47	$19.47
46505	Chemodenervation anal musc.	Y			4.8970	$194.35	$194.35	$38.87	$38.87
46600	Diagnostic anoscopy.	Y	Y		0.6211	$24.65	$24.65	$4.93	$4.93
46604	Anoscopy and dilation.	Y	Y		8.5644	$339.90	$339.90	$67.98	$67.98
46606	Anoscopy and biopsy.	Y	Y	Y	3.3278	$132.07	$132.07	$26.41	$26.41
46608	Anoscopy, remove for body.				8.5644	$339.90	$336.45	$67.98	$67.29
46610	Anoscopy, remove lesion.				20.4902	$813.22	$573.11	$162.64	$114.62
46611	Anoscopy				8.5644	$339.90	$336.45	$67.98	$67.29
46612	Anoscopy, remove lesions.				20.4902	$813.22	$573.11	$162.64	$114.62
46614	Anoscopy, control bleeding.	Y	Y	Y	2.1904	$86.93	$86.93	$17.39	$17.39
46615	Anoscopy				20.4902	$813.22	$629.61	$162.64	$125.92
46700	Repair of anal stricture.				22.2336	$882.41	$696.20	$176.48	$139.24
46706	Repr of anal fistula w/glue.				29.4386	$1,168.36	$750.68	$233.67	$150.14
46750	Repair of anal sphincter.				37.2425	$1,478.08	$994.04	$295.62	$198.81
46753	Reconstruction of anus.				22.2336	$882.41	$696.20	$176.48	$139.24
46754	Removal of suture from anus.				22.2336	$882.41	$664.20	$176.48	$132.84
46760	Repair of anal sphincter.				37.2425	$1,478.08	$962.04	$295.62	$192.41
46761	Repair of anal sphincter.				37.2425	$1,478.08	$994.04	$295.62	$198.81
46762	Implant artificial sphincter.				37.2425	$1,478.08	$1,236.54	$295.62	$247.31
46900	Destruction, anal lesion(s).	Y	Y		2.6253	$104.19	$104.19	$20.84	$20.84
46910	Destruction, anal lesion(s).	Y	Y	Y	2.9131	$115.62	$115.62	$23.12	$23.12
46916	Cryosurgery, anal lesion(s).	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
46917	Laser surgery, anal lesions.				20.5802	$816.79	$574.89	$163.36	$114.98
46922	Excision of anal lesion(s).				20.5802	$816.79	$574.89	$163.36	$114.98

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
46924	Destruction, anal lesion(s).				20.5802	$816.79	$574.89	$163.36	$114.98
46934	Destruction of hemorrhoids.	Y	Y	Y	4.4793	$177.78	$177.78	$35.56	$35.56
46935	Destruction of hemorrhoids.	Y	Y	Y	3.0462	$120.90	$120.90	$24.18	$24.18
46936	Destruction of hemorrhoids.	Y	Y	Y	4.7722	$189.40	$189.40	$37.88	$37.88
46937	Cryotherapy of rectal lesion.				22.2336	$882.41	$664.20	$176.48	$132.84
46938	Cryotherapy of rectal lesion.				29.4386	$1,168.36	$807.18	$233.67	$161.44
46940	Treatment of anal fissure.	Y	Y	Y	2.0705	$82.17	$82.17	$16.43	$16.43
46942	Treatment of anal fissure.	Y	Y	Y	1.9967	$79.25	$79.25	$15.85	$15.85
46945	Ligation of hemorrhoids.	Y	Y	Y	3.4793	$138.09	$138.09	$27.62	$27.62
46946	Ligation of hemorrhoids.	Y	Y	Y	3.6051	$143.08	$143.08	$28.62	$28.62
46947	Hemorrhoidopexy by stapling.				29.4386	$1,168.36	$839.18	$233.67	$167.84
47000	Needle biopsy of liver.				6.0729	$241.02	$287.01	$48.20	$57.40
47382	Percut ablate liver rf.	Y			39.0235	$1,548.77	$1,548.77	$309.75	$309.75
47510	Insert catheter, bile duct.				19.4515	$771.99	$609.00	$154.40	$121.80
47511	Insert bile duct drain.				19.4515	$771.99	$984.63	$154.40	$196.93
47525	Change bile duct catheter.				11.5220	$457.29	$395.14	$91.46	$79.03
47530	Revise/reinsert bile tube.				11.5220	$457.29	$395.14	$91.46	$79.03
47552	Biliary endoscopy thru skin.				19.4515	$771.99	$609.00	$154.40	$121.80
47553	Biliary endoscopy thru skin.				19.4515	$771.99	$641.00	$154.40	$128.20
47554	Biliary endoscopy thru skin.				19.4515	$771.99	$641.00	$154.40	$128.20
47555	Biliary endoscopy thru skin.				19.4515	$771.99	$641.00	$154.40	$128.20
47556	Biliary endoscopy thru skin.				19.4515	$771.99	$984.63	$154.40	$196.93
47560	Laparoscopy w/ cholangio.				31.9353	$1,267.45	$888.73	$253.49	$177.75
47561	Laparo w/ cholangio/biopsy.				31.9353	$1,267.45	$888.73	$253.49	$177.75
47562	Laparoscopic cholecystectomy.	Y			43.5124	$1,726.92	$1,726.92	$345.38	$345.38
47563	Laparo cholecystectomy/graph.	Y			43.5124	$1,726.92	$1,726.92	$345.38	$345.38
47630	Remove bile duct stone.				19.4515	$771.99	$641.00	$154.40	$128.20
48102	Needle biopsy, pancreas.				6.0729	$241.02	$287.01	$48.20	$57.40
49080	Puncture, peritoneal cavity.				3.6425	$144.56	$184.38	$28.91	$36.88
49081	Removal of abdominal fluid.				3.6425	$144.56	$184.38	$28.91	$36.88
49085	Remove abdomen foreign body.				22.1758	$880.12	$663.06	$176.02	$132.61
49180	Biopsy, abdominal mass.				6.0729	$241.02	$287.01	$48.20	$57.40

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
49250	Excision of umbilicus.				22.1758	$880.12	$755.06	$176.02	$151.01
49320	Diag laparo separate proc.				31.9353	$1,267.45	$888.73	$253.49	$177.75
49321	Laparoscopy, biopsy.				31.9353	$1,267.45	$948.73	$253.49	$189.75
49322	Laparoscopy, aspiration.				31.9353	$1,267.45	$948.73	$253.49	$189.75
49419	Insrt abdom cath for chemotx.				29.4757	$1,169.83	$751.42	$233.97	$150.28
49420	Insert abdom drain, temp.				29.2259	$1,159.92	$746.46	$231.98	$149.29
49421	Insert abdom drain, perm.				29.2259	$1,159.92	$746.46	$231.98	$149.29
49422	Remove perm cannula/catheter.				23.4666	$931.34	$632.17	$186.27	$126.43
49423	Exchange drainage catheter.	Y			11.5220	$457.29	$457.29	$91.46	$91.46
49426	Revise abdomen-venous shunt.				22.1758	$880.12	$663.06	$176.02	$132.61
49429	Removal of shunt.	Y			23.4666	$931.34	$931.34	$186.27	$186.27
49495	Rpr ing hernia baby, reduc.				29.1491	$1,156.87	$893.44	$231.37	$178.69
49496	Rpr ing hernia baby, blocked.				29.1491	$1,156.87	$893.44	$231.37	$178.69
49500	Rpr ing hernia, init, reduce.				29.1491	$1,156.87	$893.44	$231.37	$178.69
49501	Rpr ing hernia, init blocked.				29.1491	$1,156.87	$1,247.94	$231.37	$249.59
49505	Prp i/hern init reduc ≤5 yr.				29.1491	$1,156.87	$893.44	$231.37	$178.69
49507	Prp i/hern init block ≤5 yr.				29.1491	$1,156.87	$1,247.94	$231.37	$249.59
49520	Rerepair ing hernia, reduce.				29.1491	$1,156.87	$1,075.94	$231.37	$215.19
49521	Rerepair ing hernia, blocked.				29.1491	$1,156.87	$1,247.94	$231.37	$249.59
49525	Repair ing hernia, sliding.				29.1491	$1,156.87	$893.44	$231.37	$178.69
49540	Repair lumbar hernia.				29.1491	$1,156.87	$801.44	$231.37	$160.29
49550	Rpr rem hernia, init, reduce.				29.1491	$1,156.87	$936.94	$231.37	$187.39
49553	Rpr fem hernia, init blocked.				29.1491	$1,156.87	$1,247.94	$231.37	$249.59
49555	Rerepair fem hernia, reduce.				29.1491	$1,156.87	$936.94	$231.37	$187.39
49557	Rerepair fem hernia, blocked.				29.1491	$1,156.87	$1,247.94	$231.37	$249.59
49560	Rpr ventral hern init, reduc.				29.1491	$1,156.87	$893.44	$231.37	$178.69
49561	Rpr ventral hern init, block.				29.1491	$1,156.87	$1,247.94	$231.37	$249.59
49565	Rerepair ventrl hern, reduce.				29.1491	$1,156.87	$893.44	$231.37	$178.69
49566	Rerepair ventrl hern, block.				29.1491	$1,156.87	$1,247.94	$231.37	$249.59
49568	Hernia repair w/ mesh.				29.1491	$1,156.87	$1,075.94	$231.37	$215.19

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
49570	Rpr epigastric hern, reduce.				29.1491	$1,156.87	$893.44	$231.37	$178.69
49572	Rpr epigastric hern, blocked.				29.1491	$1,156.87	$1,247.94	$231.37	$249.59
49580	Rpr umbil hern, reduc < 5 yr.				29.1491	$1,156.87	$893.44	$231.37	$178.69
49582	Rpr umbil hern, block < 5 yr.				29.1491	$1,156.87	$1,247.94	$231.37	$249.59
49585	Rpr umbil hern, reduc > 5 yr.				29.1491	$1,156.87	$893.44	$231.37	$178.69
49587	Rpr umbil hern, block > 5 yr.				29.1491	$1,156.87	$1,247.94	$231.37	$249.59
49590	Repair spigelian hernia.				29.1491	$1,156.87	$833.44	$231.37	$166.69
49600	Repair umbilical lesion.				29.1491	$1,156.87	$893.44	$231.37	$178.69
49650	Laparo hernia repair initial.				43.5124	$1,726.92	$1,178.46	$345.38	$235.69
49651	Laparo hernia repair recur.				43.5124	$1,726.92	$1,360.96	$345.38	$272.19
50200	Biopsy of kidney				6.0729	$241.02	$287.01	$48.20	$57.40
50382	Change ureter stent, percut.	Y			19.2766	$765.05	$765.05	$153.01	$153.01
50384	Remove ureter stent, percut.	Y			19.2766	$765.05	$765.05	$153.01	$153.01
50387	Change ext/int ureter stent.	Y			7.2859	$289.16	$289.16	$57.83	$57.83
50389	Remove renal tube w/fluoro.	Y			3.5688	$141.64	$141.64	$28.33	$28.33
50390	Drainage of kidney lesion.				6.0729	$241.02	$287.01	$48.20	$57.40
50391	Instll rx agnt into rnal tub.	Y	Y		1.0844	$43.04	$43.04	$8.61	$8.61
50392	Insert kidney drain.				19.2766	$765.05	$549.03	$153.01	$109.81
50393	Insert ureteral tube.				19.2766	$765.05	$549.03	$153.01	$109.81
50395	Create passage to kidney.				19.2766	$765.05	$549.03	$153.01	$109.81
50396	Measure kidney pressure.				2.1159	$83.98	$107.11	$16.80	$21.42
50398	Change kidney tube.				7.2859	$289.16	$311.08	$57.83	$62.22
50551	Kidney endoscopy.				6.7325	$267.20	$300.10	$53.44	$60.02
50553	Kidney endoscopy.				19.2766	$765.05	$549.03	$153.01	$109.81
50555	Kidney endoscopy & biopsy.				6.7325	$267.20	$300.10	$53.44	$60.02
50557	Kidney endoscopy & treatment.				23.8562	$946.81	$639.90	$189.36	$127.98
50561	Kidney endoscopy & treatment.				19.2766	$765.05	$549.03	$153.01	$109.81
50562	Renal scope w/ tumor resect.	Y			6.7325	$267.20	$267.20	$53.44	$53.44
50570	Kidney endoscopy.	Y			6.7325	$267.20	$267.20	$53.44	$53.44
50572	Kidney endoscopy.	Y			6.7325	$267.20	$267.20	$53.44	$53.44
50574	Kidney endoscopy & biopsy.	Y			6.7325	$267.20	$267.20	$53.44	$53.44
50575	Kidney endoscopy.	Y			35.1024	$1,393.15	$1,393.15	$278.63	$278.63
50576	Kidney endoscopy & treatment.	Y			19.2766	$765.05	$765.05	$153.01	$153.01

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
50590	Fragmenting of kidney stone.	Y			44.1144	$1,750.82	$1,750.82	$350.16	$350.16
50592	Perc rf ablate renal tumor.	Y			39.0235	$1,548.77	$1,548.77	$309.75	$309.75
50686	Measure ureter pressure.	Y	Y		1.0844	$43.04	$43.04	$8.61	$8.61
50688	Change of ureter tube/stent.				7.2859	$289.16	$311.08	$57.83	$62.22
50947	Laparo new ureter/bladder.				43.5124	$1,726.92	$1,532.96	$345.38	$306.59
50948	Laparo new ureter/bladder.				43.5124	$1,726.92	$1,532.96	$345.38	$306.59
50951	Endoscopy of ureter.				6.7325	$267.20	$300.10	$53.44	$60.02
50953	Endoscopy of ureter.				6.7325	$267.20	$300.10	$53.44	$60.02
50955	Ureter endoscopy & biopsy.				19.2766	$765.05	$549.03	$153.01	$109.81
50957	Ureter endoscopy & treatment.				19.2766	$765.05	$549.03	$153.01	$109.81
50961	Ureter endoscopy & treatment.				19.2766	$765.05	$549.03	$153.01	$109.81
50970	Ureter endoscopy.				6.7325	$267.20	$300.10	$53.44	$60.02
50972	Ureter endoscopy & catheter.				6.7325	$267.20	$300.10	$53.44	$60.02
50974	Ureter endoscopy & biopsy.				19.2766	$765.05	$549.03	$153.01	$109.81
50976	Ureter endoscopy & treatment.				19.2766	$765.05	$549.03	$153.01	$109.81
50980	Ureter endoscopy & treatment.				19.2766	$765.05	$549.03	$153.01	$109.81
51000	Drainage of bladder.	Y	Y	Y	1.2446	$49.40	$49.40	$9.88	$9.88
51005	Drainage of bladder.	Y	Y		1.0844	$43.04	$43.04	$8.61	$8.61
51010	Drainage of bladder.				18.2333	$723.64	$528.32	$144.73	$105.66
51020	Incise & treat bladder.				23.8562	$946.81	$788.40	$189.36	$157.68
51030	Incise & treat bladder.				23.8562	$946.81	$788.40	$189.36	$157.68
51040	Incise & drain bladder.				23.8562	$946.81	$788.40	$189.36	$157.68
51045	Incise bladder/drain ureter.				6.7325	$267.20	$340.80	$53.44	$68.16
51050	Removal of bladder stone.				23.8562	$946.81	$788.40	$189.36	$157.68
51065	Remove ureter calculus.				23.8562	$946.81	$788.40	$189.36	$157.68
51080	Drainage of bladder abscess.				17.4686	$693.30	$513.15	$138.66	$102.63
51500	Removal of bladder cyst.				29.1491	$1,156.87	$893.44	$231.37	$178.69
51520	Removal of bladder lesion.				23.8562	$946.81	$788.40	$189.36	$157.68
51700	Irrigation of bladder.	Y	Y	Y	1.3433	$53.31	$53.31	$10.66	$10.66
51701	Insert bladder catheter.	Y	Y		0.6211	$24.65	$24.65	$4.93	$4.93
51702	Insert temp bladder cath.	Y	Y		0.6211	$24.65	$24.65	$4.93	$4.93

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
51703	Insert bladder cath, complex.	Y	Y		1.0844	$43.04	$43.04	$8.61	$8.61
51705	Change of bladder tube.	Y	Y	Y	1.8609	$73.85	$73.85	$14.77	$14.77
51710	Change of bladder tube.				7.2859	$289.16	$311.08	$57.83	$62.22
51715	Endoscopic injection/implant.				28.5971	$1,134.96	$822.48	$226.99	$164.50
51720	Treatment of bladder lesion.	Y	Y	Y	1.4579	$57.86	$57.86	$11.57	$11.57
51725	Simple cystometrogram.	Y	Y		2.1159	$83.98	$83.98	$16.80	$16.80
51726	Complex cystometrogram.				3.5688	$141.64	$180.65	$28.33	$36.13
51736	Urine flow measurement.	Y	Y	Y	0.6370	$25.28	$25.28	$5.06	$5.06
51741	Electro-uroflowmetry, first.	Y	Y	Y	0.8854	$35.14	$35.14	$7.03	$7.03
51772	Urethra pressure profile.				2.1159	$83.98	$107.11	$16.80	$21.42
51784	Anal/urinary muscle study.	Y	Y		1.0844	$43.04	$43.04	$8.61	$8.61
51785	Anal/urinary muscle study.				1.0844	$43.04	$54.89	$8.61	$10.98
51792	Urinary reflex study.	Y	Y		1.0844	$43.04	$43.04	$8.61	$8.61
51795	Urine voiding pressure study.	Y	Y		2.1159	$83.98	$83.98	$16.80	$16.80
51797	Intraabdominal pressure test.	Y	Y		2.1159	$83.98	$83.98	$16.80	$16.80
51798	Us urine capacity measure.	Y	Y	Y	0.4057	$16.10	$16.10	$3.22	$3.22
51880	Repair of bladder opening.				23.8562	$946.81	$639.90	$189.36	$127.98
51992	Laparo sling operation.				43.5124	$1,726.92	$1,221.96	$345.38	$244.39
52000	Cystoscopy				6.7325	$267.20	$300.10	$53.44	$60.02
52001	Cystoscopy, removal of clots.				6.7325	$267.20	$340.80	$53.44	$68.16
52005	Cystoscopy & ureter catheter.				19.2766	$765.05	$605.53	$153.01	$121.11
52007	Cystoscopy and biopsy.				19.2766	$765.05	$605.53	$153.01	$121.11
52010	Cystoscopy & duct catheter.				6.7325	$267.20	$340.80	$53.44	$68.16
52204	Cystoscopy				19.2766	$765.05	$605.53	$153.01	$121.11
52214	Cystoscopy and treatment.				23.8562	$946.81	$696.40	$189.36	$139.28
52224	Cystoscopy and treatment.				23.8562	$946.81	$696.40	$189.36	$139.28
52234	Cystoscopy and treatment.				23.8562	$946.81	$696.40	$189.36	$139.28
52235	Cystoscopy and treatment.				23.8562	$946.81	$728.40	$189.36	$145.68
52240	Cystoscopy and treatment.				23.8562	$946.81	$728.40	$189.36	$145.68
52250	Cystoscopy and radiotracer.				23.8562	$946.81	$788.40	$189.36	$157.68
52260	Cystoscopy and treatment.				19.2766	$765.05	$605.53	$153.01	$121.11
52265	Cystoscopy and treatment.	Y	Y		6.7325	$267.20	$267.20	$53.44	$53.44

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
52270	Cystoscopy & revise urethra.				19.2766	$765.05	$605.53	$153.01	$121.11
52275	Cystoscopy & revise urethra.				19.2766	$765.05	$605.53	$153.01	$121.11
52276	Cystoscopy and treatment.				19.2766	$765.05	$637.53	$153.01	$127.51
52277	Cystoscopy and treatment.				23.8562	$946.81	$696.40	$189.36	$139.28
52281	Cystoscopy and treatment.				19.2766	$765.05	$605.53	$153.01	$121.11
52282	Cystoscopy, implant stent.				35.1024	$1,393.15	$1,366.07	$278.63	$273.21
52283	Cystoscopy and treatment.				19.2766	$765.05	$605.53	$153.01	$121.11
52285	Cystoscopy and treatment.				19.2766	$765.05	$605.53	$153.01	$121.11
52290	Cystoscopy and treatment.				19.2766	$765.05	$605.53	$153.01	$121.11
52300	Cystoscopy and treatment.				19.2766	$765.05	$605.53	$153.01	$121.11
52301	Cystoscopy and treatment.				19.2766	$765.05	$637.53	$153.01	$127.51
52305	Cystoscopy and treatment.				19.2766	$765.05	$605.53	$153.01	$121.11
52310	Cystoscopy and treatment.				6.7325	$267.20	$340.80	$53.44	$68.16
52315	Cystoscopy and treatment.				19.2766	$765.05	$605.53	$153.01	$121.11
52317	Remove bladder stone.				23.8562	$946.81	$639.90	$189.36	$127.98
52318	Remove bladder stone.				23.8562	$946.81	$696.40	$189.36	$139.28
52320	Cystoscopy and treatment.				23.8562	$946.81	$831.90	$189.36	$166.38
52325	Cystoscopy, stone removal.				23.8562	$946.81	$788.40	$189.36	$157.68
52327	Cystoscopy, inject material.				23.8562	$946.81	$696.40	$189.36	$139.28
52330	Cystoscopy and treatment.				23.8562	$946.81	$696.40	$189.36	$139.28
52332	Cystoscopy and treatment.				23.8562	$946.81	$696.40	$189.36	$139.28
52334	Create passage to kidney.				23.8562	$946.81	$728.40	$189.36	$145.68
52341	Cysto w/ureter stricture tx.				23.8562	$946.81	$728.40	$189.36	$145.68
52342	Cysto w/up stricture tx.				23.8562	$946.81	$728.40	$189.36	$145.68
52343	Cysto w/renal stricture tx.				23.8562	$946.81	$728.40	$189.36	$145.68
52344	Cysto/uretero, stricture tx.				23.8562	$946.81	$728.40	$189.36	$145.68
52345	Cysto/uretero w/ up stricture.				23.8562	$946.81	$728.40	$189.36	$145.68
52346	Cystouretero w/ renal strict.				23.8562	$946.81	$728.40	$189.36	$145.68
52351	Cystouretero & or pyeloscope.				19.2766	$765.05	$637.53	$153.01	$127.51
52352	Cystouretero w/ stone remove.				23.8562	$946.81	$788.40	$189.36	$157.68
52353	Cystouretero w/ lithotripsy.				35.1024	$1,393.15	$1,011.57	$278.63	$202.31
52354	Cystouretero w/ biopsy.				23.8562	$946.81	$788.40	$189.36	$157.68
52355	Cystouretero w/ excise tumor.				23.8562	$946.81	$788.40	$189.36	$157.68
52400	Cystouretero w/ congen repr.				23.8562	$946.81	$728.40	$189.36	$145.68

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
52402	Cystourethro cut ejacul duct.				23.8562	$946.81	$728.40	$189.36	$145.68
52450	Incision of prostate.				23.8562	$946.81	$728.40	$189.36	$145.68
52500	Revision of bladder neck.				23.8562	$946.81	$728.40	$189.36	$145.68
52510	Dilation prostatic urethra.				19.2766	$765.05	$637.53	$153.01	$127.51
52601	Prostatectomy (turp).				35.1024	$1,393.15	$1,011.57	$278.63	$202.31
52606	Control postop bleeding.				23.8562	$946.81	$639.90	$189.36	$127.98
52612	Prostatectomy, first stage.				35.1024	$1,393.15	$919.57	$278.63	$183.91
52614	Prostatectomy, second stage.				35.1024	$1,393.15	$863.07	$278.63	$172.61
52620	Remove residual prostate.				35.1024	$1,393.15	$863.07	$278.63	$172.61
52630	Remove prostate regrowth.				35.1024	$1,393.15	$919.57	$278.63	$183.91
52640	Relieve bladder contracture.				23.8562	$946.81	$696.40	$189.36	$139.28
52647	Laser surgery of prostate.				42.9327	$1,703.92	$1,521.46	$340.78	$304.29
52648	Laser surgery of prostate.				42.9327	$1,703.92	$1,521.46	$340.78	$304.29
52700	Drainage of prostate abscess.				23.8562	$946.81	$696.40	$189.36	$139.28
53000	Incision of urethra.				18.5138	$734.78	$533.89	$146.96	$106.78
53010	Incision of urethra.				18.5138	$734.78	$533.89	$146.96	$106.78
53020	Incision of urethra.				18.5138	$734.78	$533.89	$146.96	$106.78
53025	Incision of urethra.	Y	Y	Y	0.3551	$14.09	$14.09	$2.82	$2.82
53040	Drainage of urethra abscess.				18.5138	$734.78	$590.39	$146.96	$118.08
53060	Drainage of urethra abscess.	Y	Y	Y	1.7500	$69.45	$69.45	$13.89	$13.89
53080	Drainage of urinary leakage.				18.5138	$734.78	$622.39	$146.96	$124.48
53085	Drainage of urinary leakage.	Y			18.5138	$734.78	$734.78	$146.96	$146.96
53200	Biopsy of urethra.				18.5138	$734.78	$533.89	$146.96	$106.78
53210	Removal of urethra.				28.5971	$1,134.96	$925.98	$226.99	$185.20
53215	Removal of urethra.				18.5138	$734.78	$725.89	$146.96	$145.18
53220	Treatment of urethra lesion.				28.5971	$1,134.96	$790.48	$226.99	$158.10
53230	Removal of urethra lesion.				28.5971	$1,134.96	$790.48	$226.99	$158.10
53235	Removal of urethra lesion.				18.5138	$734.78	$622.39	$146.96	$124.48
53240	Surgery for urethra pouch.				28.5971	$1,134.96	$790.48	$226.99	$158.10
53250	Removal of urethra gland.				18.5138	$734.78	$590.39	$146.96	$118.08
53260	Treatment of urethra lesion.				18.5138	$734.78	$590.39	$146.96	$118.08
53265	Treatment of urethra lesion.				18.5138	$734.78	$590.39	$146.96	$118.08
53270	Removal of urethra gland.				18.5138	$734.78	$590.39	$146.96	$118.08

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
53275	Repair of urethra defect.				18.5138	$734.78	$590.39	$146.96	$118.08
53400	Revise urethra, stage 1.				28.5971	$1,134.96	$822.48	$226.99	$164.50
53405	Revise urethra, stage 2.				28.5971	$1,134.96	$790.48	$226.99	$158.10
53410	Reconstruction of urethra.				28.5971	$1,134.96	$790.48	$226.99	$158.10
53420	Reconstruct urethra, stage 1.				28.5971	$1,134.96	$822.48	$226.99	$164.50
53425	Reconstruct urethra, stage 2.				28.5971	$1,134.96	$790.48	$226.99	$158.10
53430	Reconstruction of urethra.				28.5971	$1,134.96	$790.48	$226.99	$158.10
53431	Reconstruct urethra/bladder.				28.5971	$1,134.96	$790.48	$226.99	$158.10
53440	Male sling procedure.				79.3730	$3,150.16	$1,798.08	$630.03	$359.62
53442	Remove/revise male sling.				28.5971	$1,134.96	$733.98	$226.99	$146.80
53444	Insert tandem cuff.				79.3730	$3,150.16	$1,798.08	$630.03	$359.62
53445	Insert uro/vesnck sphincter.				135.7295	$5,386.84	$2,859.92	$1,077.37	$571.98
53446	Remove uro sphincter.				28.5971	$1,134.96	$733.98	$226.99	$146.80
53447	Remove/replace ur sphincter.				135.7295	$5,386.84	$2,859.92	$1,077.37	$571.98
53449	Repair uro sphincter.				28.5971	$1,134.96	$733.98	$226.99	$146.80
53450	Revision of urethra.				28.5971	$1,134.96	$733.98	$226.99	$146.80
53460	Revision of urethra.				18.5138	$734.78	$533.89	$146.96	$106.78
53502	Repair of urethra injury.				18.5138	$734.78	$590.39	$146.96	$118.08
53505	Repair of urethra injury.				28.5971	$1,134.96	$790.48	$226.99	$158.10
53510	Repair of urethra injury.				18.5138	$734.78	$590.39	$146.96	$118.08
53515	Repair of urethra injury.				28.5971	$1,134.96	$790.48	$226.99	$158.10
53520	Repair of urethra defect.				28.5971	$1,134.96	$790.48	$226.99	$158.10
53600	Dilate urethra stricture.	Y	Y	Y	0.9900	$39.29	$39.29	$7.86	$7.86
53601	Dilate urethra stricture.	Y	Y		1.0844	$43.04	$43.04	$8.61	$8.61
53605	Dilate urethra stricture.				19.2766	$765.05	$605.53	$153.01	$121.11
53620	Dilate urethra stricture.	Y	Y	Y	1.6003	$63.51	$63.51	$12.70	$12.70
53621	Dilate urethra stricture.	Y	Y	Y	1.6839	$66.83	$66.83	$13.37	$13.37
53660	Dilation of urethra.	Y	Y		1.0844	$43.04	$43.04	$8.61	$8.61
53661	Dilation of urethra.	Y	Y		1.0844	$43.04	$43.04	$8.61	$8.61
53665	Dilation of urethra.				18.5138	$734.78	$533.89	$146.96	$106.78
53850	Prostatic microwave thermotx.	Y	Y		42.3176	$1,679.50	$1,679.50	$335.90	$335.90
53852	Prostatic rf thermotx.	Y	Y		42.3176	$1,679.50	$1,679.50	$335.90	$335.90

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
53853	Prostatic water thermother.	Y	Y		23.8562	$946.81	$946.81	$189.36	$189.36
54000	Slitting of prepuce.				18.5138	$734.78	$590.39	$146.96	$118.08
54001	Slitting of prepuce.				18.5138	$734.78	$590.39	$146.96	$118.08
54015	Drain penis lesion.				17.4686	$693.30	$661.65	$138.66	$132.33
54050	Destruction, penis lesion(s).	Y	Y		1.0876	$43.16	$43.16	$8.63	$8.63
54055	Destruction, penis lesion(s).	Y	Y	Y	1.5372	$61.01	$61.01	$12.20	$12.20
54056	Cryosurgery, penis lesion(s).	Y	Y		0.8076	$32.05	$32.05	$6.41	$6.41
54057	Laser surg, penis lesion(s).				17.7392	$704.03	$518.52	$140.81	$103.70
54060	Excision of penis lesion(s).				17.7392	$704.03	$518.52	$140.81	$103.70
54065	Destruction, penis lesion(s).				20.5802	$816.79	$574.89	$163.36	$114.98
54100	Biopsy of penis				14.9563	$593.59	$463.29	$118.72	$92.66
54105	Biopsy of penis				19.9760	$792.81	$562.90	$158.56	$112.58
54110	Treatment of penis lesion.				32.9991	$1,309.67	$877.84	$261.93	$175.57
54111	Treat penis lesion, graft.				32.9991	$1,309.67	$877.84	$261.93	$175.57
54112	Treat penis lesion, graft.				32.9991	$1,309.67	$877.84	$261.93	$175.57
54115	Treatment of penis lesion.				17.4686	$693.30	$513.15	$138.66	$102.63
54120	Partial removal of penis.				32.9991	$1,309.67	$877.84	$261.93	$175.57
54150	Circumcision				20.7418	$823.20	$578.10	$164.64	$115.62
54152	Circumcision				20.7418	$823.20	$578.10	$164.64	$115.62
54160	Circumcision				20.7418	$823.20	$634.60	$164.64	$126.92
54161	Circumcision				20.7418	$823.20	$634.60	$164.64	$126.92
54162	Lysis penil circumic lesion.				20.7418	$823.20	$634.60	$164.64	$126.92
54163	Repair of circumcision.				20.7418	$823.20	$634.60	$164.64	$126.92
54164	Frenulotomy of penis.				20.7418	$823.20	$634.60	$164.64	$126.92
54200	Treatment of penis lesion.	Y	Y	Y	1.6501	$65.49	$65.49	$13.10	$13.10
54205	Treatment of penis lesion.				32.9991	$1,309.67	$969.84	$261.93	$193.97
54220	Treatment of penis lesion.				2.1159	$83.98	$107.11	$16.80	$21.42
54231	Dynamic cavernosometry.	Y	Y	Y	1.3889	$55.12	$55.12	$11.02	$11.02
54235	Penile injection	Y	Y	Y	1.0170	$40.36	$40.36	$8.07	$8.07
54240	Penis study	Y	Y	Y	1.0844	$43.04	$43.04	$8.61	$8.61
54250	Penis study	Y	Y	Y	0.9079	$36.03	$36.03	$7.21	$7.21
54300	Revision of penis.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54304	Revision of penis.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54308	Reconstruction of urethra.				32.9991	$1,309.67	$909.84	$261.93	$181.97

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
54312	Reconstruction of urethra.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54316	Reconstruction of urethra.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54318	Reconstruction of urethra.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54322	Reconstruction of urethra.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54324	Reconstruction of urethra.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54326	Reconstruction of urethra.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54328	Revise penis/urethra.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54340	Secondary urethral surgery.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54344	Secondary urethral surgery.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54348	Secondary urethral surgery.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54352	Reconstruct urethra/penis.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54360	Penis plastic surgery.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54380	Repair penis				32.9991	$1,309.67	$909.84	$261.93	$181.97
54385	Repair penis				32.9991	$1,309.67	$909.84	$261.93	$181.97
54400	Insert semi-rigid prosthesis.				79.3730	$3,150.16	$1,830.08	$630.03	$366.02
54401	Insert self-contd prosthesis.				135.7295	$5,386.84	$2,948.42	$1,077.37	$589.68
54405	Insert multi-comp penis pros.				135.7295	$5,386.84	$2,948.42	$1,077.37	$589.68
54406	Remove muti-comp penis pros.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54408	Repair multi-comp penis pros.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54410	Remove/replace penis prosth.				135.7295	$5,386.84	$2,948.42	$1,077.37	$589.68
54415	Remove self-contd penis pros.				32.9991	$1,309.67	$909.84	$261.93	$181.97
54416	Remv/repl penis contain pros.				135.7295	$5,386.84	$2,948.42	$1,077.37	$589.68
54420	Revision of penis.				32.9991	$1,309.67	$969.84	$261.93	$193.97
54435	Revision of penis.				32.9991	$1,309.67	$969.84	$261.93	$193.97
54440	Repair of penis				32.9991	$1,309.67	$969.84	$261.93	$193.97
54450	Preputial stretching.				3.5688	$141.64	$180.65	$28.33	$36.13
54500	Biopsy of testis				10.2616	$407.26	$370.13	$81.45	$74.03
54505	Biopsy of testis				23.7072	$940.89	$636.95	$188.18	$127.39
54512	Excise lesion testis.				23.7072	$940.89	$693.45	$188.18	$138.69
54520	Removal of testis.				23.7072	$940.89	$725.45	$188.18	$145.09
54522	Orchiectomy, partial.				23.7072	$940.89	$725.45	$188.18	$145.09
54530	Removal of testis.				29.1491	$1,156.87	$893.44	$231.37	$178.69
54550	Exploration for testis.				29.1491	$1,156.87	$893.44	$231.37	$178.69

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
54560	Exploration for testis.	Y			23.7072	$940.89	$940.89	$188.18	$188.18
54600	Reduce testis torsion.				23.7072	$940.89	$785.45	$188.18	$157.09
54620	Suspension of testis.				23.7072	$940.89	$725.45	$188.18	$145.09
54640	Suspension of testis.				29.1491	$1,156.87	$893.44	$231.37	$178.69
54660	Revision of testis.				23.7072	$940.89	$693.45	$188.18	$138.69
54670	Repair testis injury.				23.7072	$940.89	$725.45	$188.18	$145.09
54680	Relocation of testis(es).				23.7072	$940.89	$725.45	$188.18	$145.09
54690	Laparoscopy, orchiectomy.				43.5124	$1,726.92	$1,532.96	$345.38	$306.59
54700	Drainage of scrotum.				23.7072	$940.89	$693.45	$188.18	$138.69
54800	Biopsy of epididymis.				2.0863	$82.80	$105.61	$16.56	$21.12
54820	Exploration of epididymis.				23.7072	$940.89	$636.95	$188.18	$127.39
54830	Remove epididymis lesion.				23.7072	$940.89	$725.45	$188.18	$145.09
54840	Remove epididymis lesion.				23.7072	$940.89	$785.45	$188.18	$157.09
54860	Removal of epididymis.				23.7072	$940.89	$725.45	$188.18	$145.09
54861	Removal of epididymis.				23.7072	$940.89	$785.45	$188.18	$157.09
54900	Fusion of spermatic ducts.				23.7072	$940.89	$785.45	$188.18	$157.09
54901	Fusion of spermatic ducts.				23.7072	$940.89	$785.45	$188.18	$157.09
55000	Drainage of hydrocele.	Y	Y	Y	1.6905	$67.09	$67.09	$13.42	$13.42
55040	Removal of hydrocele.				29.1491	$1,156.87	$833.44	$231.37	$166.69
55041	Removal of hydroceles.				29.1491	$1,156.87	$936.94	$231.37	$187.39
55060	Repair of hydrocele.				23.7072	$940.89	$785.45	$188.18	$157.09
55100	Drainage of scrotum abscess.				10.9184	$433.33	$383.17	$86.67	$76.63
55110	Explore scrotum				23.7072	$940.89	$693.45	$188.18	$138.69
55120	Removal of scrotum lesion.				23.7072	$940.89	$693.45	$188.18	$138.69
55150	Removal of scrotum.				23.7072	$940.89	$636.95	$188.18	$127.39
55175	Revision of scrotum.				23.7072	$940.89	$636.95	$188.18	$127.39
55180	Revision of scrotum.				23.7072	$940.89	$693.45	$188.18	$138.69
55200	Incision of sperm duct.				23.7072	$940.89	$693.45	$188.18	$138.69
55250	Removal of sperm duct(s).				23.7072	$940.89	$693.45	$188.18	$138.69
55400	Repair of sperm duct.				23.7072	$940.89	$636.95	$188.18	$127.39
55450	Ligation of sperm duct.	Y	Y	Y	5.6047	$222.44	$222.44	$44.49	$44.49
55500	Removal of hydrocele.				23.7072	$940.89	$725.45	$188.18	$145.09
55520	Removal of sperm cord lesion.				23.7072	$940.89	$785.45	$188.18	$157.09

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
55530	Revise spermatic cord veins.				23.7072	$940.89	$785.45	$188.18	$157.09
55535	Revise spermatic cord veins.				29.1491	$1,156.87	$893.44	$231.37	$178.69
55540	Revise hernia & sperm veins.				29.1491	$1,156.87	$936.94	$231.37	$187.39
55550	Laparo ligate spermatic vein.				43.5124	$1,726.92	$1,532.96	$345.38	$306.59
55559	Laparo proc, spermatic cord.	Y			31.9353	$1,267.45	$1,267.45	$253.49	$253.49
55600	Incise sperm duct pouch.	Y	Y	Y	3.5462	$140.74	$140.74	$28.15	$28.15
55680	Remove sperm pouch lesion.				23.7072	$940.89	$636.95	$188.18	$127.39
55700	Biopsy of prostate.				5.9892	$237.70	$303.17	$47.54	$60.63
55705	Biopsy of prostate.				5.9892	$237.70	$303.17	$47.54	$60.63
55720	Drainage of prostate abscess.				23.8562	$946.81	$639.90	$189.36	$127.98
55725	Drainage of prostate abscess.				23.8562	$946.81	$696.40	$189.36	$139.28
55859	Percut/needle insert, pros.				35.1024	$1,393.15	$1,366.07	$278.63	$273.21
55860	Surgical exposure, prostate.	Y			18.2333	$723.64	$723.64	$144.73	$144.73
55870	Electroejaculation.	Y	Y	Y	1.7213	$68.32	$68.32	$13.66	$13.66
55873	Cryoablate prostate.				107.8298	$4,279.56	$2,809.28	$855.91	$561.86
56405	I & D of vulva/perineum.	Y	Y	Y	1.0685	$42.41	$42.41	$8.48	$8.48
56420	Drainage of gland abscess.	Y	Y		1.4050	$55.76	$55.76	$11.15	$11.15
56440	Surgery for vulva lesion.				20.5113	$814.05	$630.03	$162.81	$126.01
56441	Lysis of labial lesion(s).				14.7958	$587.22	$460.11	$117.44	$92.02
56501	Destroy, vulva lesions, sim.	Y	Y	Y	1.4690	$58.30	$58.30	$11.66	$11.66
56515	Destroy vulva lesion/s compl.				20.5802	$816.79	$663.39	$163.36	$132.68
56605	Biopsy of vulva/perineum.	Y	Y	Y	0.8450	$33.54	$33.54	$6.71	$6.71
56606	Biopsy of vulva/perineum.	Y	Y	Y	0.3647	$14.47	$14.47	$2.89	$2.89
56620	Partial removal of vulva.				28.7410	$1,140.68	$928.84	$228.14	$185.77
56625	Complete removal of vulva.				28.7410	$1,140.68	$1,067.84	$228.14	$213.57
56700	Partial removal of hymen.				20.5113	$814.05	$573.53	$162.81	$114.71
56720	Incision of hymen.				14.7958	$587.22	$460.11	$117.44	$92.02
56740	Remove vagina gland lesion.				20.5113	$814.05	$662.03	$162.81	$132.41
56800	Repair of vagina				20.5113	$814.05	$662.03	$162.81	$132.41
56810	Repair of perineum.				20.5113	$814.05	$765.53	$162.81	$153.11

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
56820	Exam of vulva w/scope.	Y	Y	Y	1.0682	$42.39	$42.39	$8.48	$8.48
56821	Exam/biopsy of vulva w/scope.	Y	Y	Y	1.4089	$55.92	$55.92	$11.18	$11.18
57000	Exploration of vagina.				14.7958	$587.22	$460.11	$117.44	$92.02
57010	Drainage of pelvic abscess.				14.7958	$587.22	$516.61	$117.44	$103.32
57020	Drainage of pelvic fluid.				6.9265	$274.90	$350.61	$54.98	$70.12
57022	I & d vaginal hematoma, pp.	Y			10.9184	$433.33	$433.33	$86.67	$86.67
57023	I& d vag hematoma, non-ob.				17.4686	$693.30	$513.15	$138.66	$102.63
57061	Destroy vag lesions, simple.	Y	Y	Y	1.3555	$53.80	$53.80	$10.76	$10.76
57065	Destroy vag lesions, complex.				20.5113	$814.05	$573.53	$162.81	$114.71
57100	Biopsy of vagina.	Y	Y	Y	0.8573	$34.02	$34.02	$6.80	$6.80
57105	Biopsy of vagina.				20.5113	$814.05	$630.03	$162.81	$126.01
57130	Remove vagina lesion.				20.5113	$814.05	$630.03	$162.81	$126.01
57135	Remove vagina lesion.				20.5113	$814.05	$630.03	$162.81	$126.01
57150	Treat vagina infection.	Y	Y		0.1501	$5.96	$5.96	$1.19	$1.19
57155	Insert uteri tandems/ovoids.				6.9265	$274.90	$350.61	$54.98	$70.12
57160	Insert pessary/other device.	Y	Y	Y	0.8815	$34.98	$34.98	$7.00	$7.00
57170	Fitting of diaphragm/cap.	Y	Y		0.1501	$5.96	$5.96	$1.19	$1.19
57180	Treat vaginal bleeding.				2.9902	$118.68	$151.36	$23.74	$30.27
57200	Repair of vagina				20.5113	$814.05	$573.53	$162.81	$114.71
57210	Repair vagina/perineum.				20.5113	$814.05	$630.03	$162.81	$126.01
57220	Revision of urethra.				42.8756	$1,701.65	$1,105.83	$340.33	$221.17
57230	Repair of urethral lesion.				28.7410	$1,140.68	$825.34	$228.14	$165.07
57240	Repair bladder & vagina.				28.7410	$1,140.68	$928.84	$228.14	$185.77
57250	Repair rectum & vagina.				28.7410	$1,140.68	$928.84	$228.14	$185.77
57260	Repair of vagina				28.7410	$1,140.68	$928.84	$228.14	$185.77
57265	Extensive repair of vagina.				42.8756	$1,701.65	$1,348.33	$340.33	$269.67
57268	Repair of bowel bulge.				28.7410	$1,140.68	$825.34	$228.14	$165.07
57287	Revise/remove sling repair.	Y			28.7410	$1,140.68	$1,140.68	$228.14	$228.14
57288	Repair bladder defect.				42.8756	$1,701.65	$1,209.33	$340.33	$241.87
57289	Repair bladder & vagina.				28.7410	$1,140.68	$928.84	$228.14	$185.77
57291	Construction of vagina.				28.7410	$1,140.68	$928.84	$228.14	$185.77
57300	Repair rectum-vagina fistula.				28.7410	$1,140.68	$825.34	$228.14	$165.07
57320	Repair bladder-vagina lesion.	Y			28.7410	$1,140.68	$1,140.68	$228.14	$228.14

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
57400	Dilation of vagina.				20.5113	$814.05	$630.03	$162.81	$126.01
57410	Pelvic examination.				14.7958	$587.22	$516.61	$117.44	$103.32
57415	Remove vaginal foreign body.				20.5113	$814.05	$630.03	$162.81	$126.01
57420	Exam of vagina w/scope.	Y	Y	Y	1.1018	$43.73	$43.73	$8.75	$8.75
57421	Exam/biopsy of vag w/scope.	Y	Y	Y	1.4710	$58.38	$58.38	$11.68	$11.68
57452	Examination of vagina.	Y	Y	Y	1.0518	$41.75	$41.75	$8.35	$8.35
57454	Vagina examination & biopsy.	Y	Y	Y	1.2983	$51.53	$51.53	$10.31	$10.31
57455	Biopsy of cervix w/scope.	Y	Y	Y	1.3775	$54.67	$54.67	$10.93	$10.93
57456	Endocerv curettage w/scope.	Y	Y	Y	1.3315	$52.85	$52.85	$10.57	$10.57
57460	Cervix excision	Y	Y	Y	4.3623	$173.13	$173.13	$34.63	$34.63
57461	Conz of cervix w/scope, leep.	Y	Y	Y	4.6015	$182.62	$182.62	$36.52	$36.52
57500	Biopsy of cervix	Y	Y	Y	1.9587	$77.74	$77.74	$15.55	$15.55
57505	Endocervical curettage.	Y	Y	Y	1.1880	$47.15	$47.15	$9.43	$9.43
57510	Cauterization of cervix.	Y	Y	Y	1.2257	$48.65	$48.65	$9.73	$9.73
57511	Cryocautery of cervix.	Y	Y		1.4050	$55.76	$55.76	$11.15	$11.15
57513	Laser surgery of cervix.				14.7958	$587.22	$516.61	$117.44	$103.32
57520	Conization of cervix.				20.5113	$814.05	$630.03	$162.81	$126.01
57522	Conization of cervix.				28.7410	$1,140.68	$793.34	$228.14	$158.67
57530	Removal of cervix.				28.7410	$1,140.68	$825.34	$228.14	$165.07
57550	Removal of residual cervix.				28.7410	$1,140.68	$825.34	$228.14	$165.07
57556	Remove cervix, repair bowel.				42.8756	$1,701.65	$1,209.33	$340.33	$241.87
57700	Revision of cervix.				20.5113	$814.05	$573.53	$162.81	$114.71
57720	Revision of cervix.				20.5113	$814.05	$662.03	$162.81	$132.41
57800	Dilation of cervical canal.	Y	Y	Y	0.6280	$24.92	$24.92	$4.98	$4.98
57820	D& c of residual cervix.				17.7635	$705.00	$607.50	$141.00	$121.50
58100	Biopsy of uterus lining.	Y	Y	Y	1.0495	$41.65	$41.65	$8.33	$8.33
58110	Bx done w/colposcopy add-on.	Y	Y	Y	0.4041	$16.04	$16.04	$3.21	$3.21
58120	Dilation and curettage.				17.7635	$705.00	$575.50	$141.00	$115.10
58145	Myomectomy vag method.				28.7410	$1,140.68	$928.84	$228.14	$185.77
58301	Remove intrauterine device.	Y	Y	Y	1.0140	$40.24	$40.24	$8.05	$8.05
58321	Artificial insemination.	Y	Y	Y	0.9178	$36.42	$36.42	$7.28	$7.28
58322	Artificial insemination.	Y	Y	Y	0.9612	$38.15	$38.15	$7.63	$7.63
58323	Sperm washing	Y	Y	Y	0.2946	$11.69	$11.69	$2.34	$2.34
58345	Reopen fallopian tube.	Y	Y	Y	1.9449	$77.19	$77.19	$15.44	$15.44

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
58346	Insert heyman uteri capsule.				14.7958	$587.22	$516.61	$117.44	$103.32
58350	Reopen fallopian tube.				28.7410	$1,140.68	$825.34	$228.14	$165.07
58353	Endometr ablate, thermal.				28.7410	$1,140.68	$885.34	$228.14	$177.07
58356	Endometrial cryoablation.	Y	Y		42.8756	$1,701.65	$1,701.65	$340.33	$340.33
58545	Laparoscopic myomectomy.				31.9353	$1,267.45	$1,303.23	$253.49	$260.65
58546	Laparo-myomectomy, complex.				43.5124	$1,726.92	$1,532.96	$345.38	$306.59
58550	Laparo-asst vag hysterectomy.				70.8854	$2,813.31	$2,076.15	$562.66	$415.23
58552	Laparo-vag hyst incl t/o.	Y			43.5124	$1,726.92	$1,726.92	$345.38	$345.38
58555	Hysteroscopy, dx, sep proc.				21.4199	$850.11	$591.56	$170.02	$118.31
58558	Hysteroscopy, biopsy.				21.4199	$850.11	$680.06	$170.02	$136.01
58559	Hysteroscopy, lysis.				21.4199	$850.11	$648.06	$170.02	$129.61
58560	Hysteroscopy, resect septum.				33.3029	$1,321.73	$915.86	$264.35	$183.17
58561	Hysteroscopy, remove myoma.				33.3029	$1,321.73	$915.86	$264.35	$183.17
58562	Hysteroscopy, remove fb.				21.4199	$850.11	$680.06	$170.02	$136.01
58563	Hysteroscopy, ablation.				33.3029	$1,321.73	$975.86	$264.35	$195.17
58565	Hysteroscopy, sterilization.				42.8756	$1,701.65	$1,165.83	$340.33	$233.17
58600	Division of fallopian tube.	Y			28.7410	$1,140.68	$1,140.68	$228.14	$228.14
58615	Occlude fallopian tube(s).	Y			20.5113	$814.05	$814.05	$162.81	$162.81
58660	Laparoscopy, lysis.				43.5124	$1,726.92	$1,221.96	$345.38	$244.39
58661	Laparoscopy, remove adnexa.				43.5124	$1,726.92	$1,221.96	$345.38	$244.39
58662	Laparoscopy, excise lesions.				43.5124	$1,726.92	$1,221.96	$345.38	$244.39
58670	Laparoscopy, tubal cautery.				43.5124	$1,726.92	$1,118.46	$345.38	$223.69
58671	Laparoscopy, tubal block.				43.5124	$1,726.92	$1,118.46	$345.38	$223.69
58672	Laparoscopy, fimbrioplasty.				43.5124	$1,726.92	$1,221.96	$345.38	$244.39
58673	Laparoscopy, salpingostomy.				43.5124	$1,726.92	$1,221.96	$345.38	$244.39
58800	Drainage of ovarian cyst(s).				14.7958	$587.22	$548.61	$117.44	$109.72
58820	Drain ovary abscess, open.				28.7410	$1,140.68	$825.34	$228.14	$165.07
58900	Biopsy of ovary(s).				14.7958	$587.22	$548.61	$117.44	$109.72
58970	Retrieval of oocyte.				4.4108	$175.06	$223.27	$35.01	$44.65
58974	Transfer of embryo.				4.4108	$175.06	$223.27	$35.01	$44.65
58976	Transfer of embryo.				4.4108	$175.06	$223.27	$35.01	$44.65
59000	Amniocentesis, diagnostic.	Y	Y		1.4026	$55.67	$55.67	$11.13	$11.13

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
59001	Amniocentesis, therapeutic.	Y	Y	Y	1.0624	$42.16	$42.16	$8.43	$8.43
59012	Fetal cord puncture,prenatal.	Y			1.4026	$55.67	$55.67	$11.13	$11.13
59015	Chorion biopsy	Y	Y	Y	1.2728	$50.52	$50.52	$10.10	$10.10
59020	Fetal contract stress test.	Y	Y	Y	0.7961	$31.60	$31.60	$6.32	$6.32
59025	Fetal non-stress test.	Y	Y	Y	0.4581	$18.18	$18.18	$3.64	$3.64
59070	Transabdom amnioinfus w/us.	Y			1.4026	$55.67	$55.67	$11.13	$11.13
59072	Umbilical cord occlud w/us.	Y			1.4026	$55.67	$55.67	$11.13	$11.13
59076	Fetal shunt placement, w/us.	Y			1.4026	$55.67	$55.67	$11.13	$11.13
59100	Remove uterus lesion.	Y	Y	Y	5.2552	$208.57	$208.57	$41.71	$41.71
59150	Treat ectopic pregnancy.	Y			43.5124	$1,726.92	$1,726.92	$345.38	$345.38
59151	Treat ectopic pregnancy.	Y			43.5124	$1,726.92	$1,726.92	$345.38	$345.38
59160	D& c after delivery.				17.7635	$705.00	$607.50	$141.00	$121.50
59200	Insert cervical dilator.	Y	Y	Y	0.9139	$36.27	$36.27	$7.25	$7.25
59300	Episiotomy or vaginal repair.	Y	Y	Y	1.8766	$74.48	$74.48	$14.90	$14.90
59320	Revision of cervix.				20.5113	$814.05	$573.53	$162.81	$114.71
59412	Antepartum manipulation.	Y			2.8011	$111.17	$111.17	$22.23	$22.23
59812	Treatment of miscarriage.				18.5251	$735.23	$726.11	$147.05	$145.22
59820	Care of miscarriage.				18.5251	$735.23	$726.11	$147.05	$145.22
59821	Treatment of miscarriage.				18.5251	$735.23	$726.11	$147.05	$145.22
59840	Abortion				17.2607	$685.04	$701.02	$137.01	$140.20
59841	Abortion				17.2607	$685.04	$701.02	$137.01	$140.20
59866	Abortion (mpr)	Y			1.4026	$55.67	$55.67	$11.13	$11.13
59870	Evacuate mole of uterus.				18.5251	$735.23	$726.11	$147.05	$145.22
59871	Remove cerclage suture.				20.5113	$814.05	$765.53	$162.81	$153.11
60000	Drain thyroid/tongue cyst.				7.7261	$306.63	$319.82	$61.33	$63.96
60001	Aspirate/inject thyriod cyst.	Y	Y	Y	1.4633	$58.08	$58.08	$11.62	$11.62
60100	Biopsy of thyroid.	Y	Y	Y	1.1901	$47.23	$47.23	$9.45	$9.45
60200	Remove thyroid lesion.				37.1283	$1,473.55	$959.78	$294.71	$191.96
60280	Remove thyroid duct lesion.				37.1283	$1,473.55	$1,051.78	$294.71	$210.36
60281	Remove thyroid duct lesion.				37.1283	$1,473.55	$1,051.78	$294.71	$210.36
61000	Remove cranial cavity fluid.	Y	Y	Y	0.9167	$36.38	$36.38	$7.28	$7.28
61001	Remove cranial cavity fluid.	Y	Y	Y	0.9655	$38.32	$38.32	$7.66	$7.66
61020	Remove brain cavity fluid.				3.0383	$120.58	$153.80	$24.12	$30.76
61026	Injection into brain canal.				3.0383	$120.58	$153.80	$24.12	$30.76

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
61050	Remove brain canal fluid.				3.0383	$120.58	$153.80	$24.12	$30.76
61055	Injection into brain canal.				3.0383	$120.58	$153.80	$24.12	$30.76
61070	Brain canal shunt procedure.				3.0383	$120.58	$153.80	$24.12	$30.76
61215	Insert brain-fluid device.				45.6712	$1,812.60	$1,161.30	$362.52	$232.26
61330	Decompress eye socket.	Y			37.7719	$1,499.09	$1,499.09	$299.82	$299.82
61334	Explore orbit/remove object.	Y			37.7719	$1,499.09	$1,499.09	$299.82	$299.82
61790	Treat trigeminal nerve.				17.7609	$704.90	$607.45	$140.98	$121.49
61791	Treat trigeminal tract.				5.5439	$220.03	$280.63	$44.01	$56.13
61795	Brain surgery using computer.	Y			5.5005	$218.30	$218.30	$43.66	$43.66
61880	Revise/remove neuroelectrode.	Y			17.1830	$681.96	$681.96	$136.39	$136.39
61885	Insrt/redo neurostim 1 array.				175.9328	$6,982.44	$3,714.22	$1,396.49	$742.84
61886	Implant neurostim arrays.				235.5774	$9,349.62	$4,929.81	$1,869.92	$985.96
61888	Revise/remove neuroreceiver.				33.9521	$1,347.49	$840.25	$269.50	$168.05
62194	Replace/irrigate catheter.				11.5220	$457.29	$395.14	$91.46	$79.03
62225	Replace/irrigate catheter.				11.5220	$457.29	$395.14	$91.46	$79.03
62230	Replace/revise brain shunt.				45.6712	$1,812.60	$1,129.30	$362.52	$225.86
62252	Csf shunt reprogram.	Y	Y	Y	1.1258	$44.68	$44.68	$8.94	$8.94
62263	Epidural lysis mult sessions.				12.4432	$493.85	$413.42	$98.77	$82.68
62264	Epidural lysis on single day.				12.4432	$493.85	$413.42	$98.77	$82.68
62268	Drain spinal cord cyst.				3.0383	$120.58	$153.80	$24.12	$30.76
62269	Needle biopsy, spinal cord.				6.0729	$241.02	$287.01	$48.20	$57.40
62270	Spinal fluid tap, diagnostic.				2.2491	$89.26	$113.85	$17.85	$22.77
62272	Drain cerebro spinal fluid.				2.2491	$89.26	$113.85	$17.85	$22.77
62273	Inject epidural patch.				5.5439	$220.03	$276.51	$44.01	$55.30
62280	Treat spinal cord lesion.				6.3788	$253.16	$293.08	$50.63	$58.62
62281	Treat spinal cord lesion.				6.3788	$253.16	$293.08	$50.63	$58.62
62282	Treat spinal canal lesion.				6.3788	$253.16	$293.08	$50.63	$58.62
62287	Percutaneous diskectomy.				33.3035	$1,321.75	$1,330.38	$264.35	$266.08
62292	Injection into disk lesion.	Y			3.0383	$120.58	$120.58	$24.12	$24.12
62294	Injection into spinal artery.				3.0383	$120.58	$153.80	$24.12	$30.76
62310	Inject spine c/t				6.3788	$253.16	$293.08	$50.63	$58.62
62311	Inject spine l/s (cd).				6.3788	$253.16	$293.08	$50.63	$58.62

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
62318	Inject spine w/ cath, c/t.				6.3788	$253.16	$293.08	$50.63	$58.62
62319	Inject spine w/ cath l/s (cd).				6.3788	$253.16	$293.08	$50.63	$58.62
62350	Implant spinal canal cath.				29.2931	$1,162.59	$804.29	$232.52	$160.86
62355	Remove spinal canal catheter.				12.4432	$493.85	$469.92	$98.77	$93.98
62360	Insert spine infusion device.				112.0147	$4,445.65	$2,445.82	$889.13	$489.16
62361	Implant spine infusion pump.				183.1974	$7,270.75	$3,858.38	$1,454.15	$771.68
62362	Implant spine infusion pump.				183.1974	$7,270.75	$3,858.38	$1,454.15	$771.68
62365	Remove spine infusion device.				33.3035	$1,321.75	$883.88	$264.35	$176.78
62367	Analyze spine infusion pump.	Y	Y	Y	0.4369	$17.34	$17.34	$3.47	$3.47
62368	Analyze spine infusion pump.	Y	Y	Y	0.5519	$21.90	$21.90	$4.38	$4.38
63600	Remove spinal cord lesion.				17.7609	$704.90	$575.45	$140.98	$115.09
63610	Stimulation of spinal cord.				17.7609	$704.90	$518.95	$140.98	$103.79
63615	Remove lesion of spinal cord.	Y	Y	Y	6.2719	$248.92	$248.92	$49.78	$49.78
63650	Implant neuroelectrodes.				56.3855	$2,237.83	$1,341.92	$447.57	$268.38
63655	Implant neuroelectrodes.	Y			84.2373	$3,343.22	$3,343.22	$668.64	$668.64
63660	Revise/remove neuroelectrode.				17.1830	$681.96	$507.48	$136.39	$101.50
63685	Insrt/redo spine n generator.				178.1307	$7,069.67	$3,757.83	$1,413.93	$751.57
63688	Revise/remove neuroreceiver.				33.9521	$1,347.49	$840.25	$269.50	$168.05
63744	Revision of spinal shunt.				36.1603	$1,435.13	$972.57	$287.03	$194.51
63746	Removal of spinal shunt.				10.9541	$434.75	$440.37	$86.95	$88.07
64400	N block inj, trigeminal.	Y	Y	Y	1.4194	$56.33	$56.33	$11.27	$11.27
64402	N block inj, facial.	Y	Y	Y	1.3219	$52.46	$52.46	$10.49	$10.49
64405	N block inj, occipital.	Y	Y	Y	1.1245	$44.63	$44.63	$8.93	$8.93
64408	N block inj, vagus.	Y	Y	Y	1.3388	$53.13	$53.13	$10.63	$10.63
64410	Nblock inj, phrenic.				5.5439	$220.03	$276.51	$44.01	$55.30
64412	N block inj, spinal accessor.	Y	Y	Y	2.0074	$79.67	$79.67	$15.93	$15.93
64413	N block inj, cervical plexus.	Y	Y	Y	1.3483	$53.51	$53.51	$10.70	$10.70
64415	Nblock inj, brachial plexus.				2.2491	$89.26	$113.85	$17.85	$22.77
64416	N block cont infuse, b plex.	Y			2.2491	$89.26	$89.26	$17.85	$17.85
64417	Nblock inj, axillary.				2.2491	$89.26	$113.85	$17.85	$22.77
64418	N block inj, suprascapular.	Y	Y	Y	1.9395	$76.98	$76.98	$15.40	$15.40

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
64420	Nblock inj, intercost, sng.				2.2491	$89.26	$113.85	$17.85	$22.77
64421	Nblock inj, intercost, mlt.				5.5439	$220.03	$276.51	$44.01	$55.30
64425	N block inj ilioing/hypogi.	Y	Y	Y	1.2794	$50.78	$50.78	$10.16	$10.16
64430	Nblock inj, pudendal.				2.2491	$89.26	$113.85	$17.85	$22.77
64435	N block inj, paracervical.	Y	Y	Y	1.9447	$77.18	$77.18	$15.44	$15.44
64445	Injection for nerve block.	Y	Y	Y	1.8559	$73.66	$73.66	$14.73	$14.73
64450	N block, other peripheral.	Y	Y	Y	1.0671	$42.35	$42.35	$8.47	$8.47
64470	Inj paravertebral c/t.				6.3788	$253.16	$293.08	$50.63	$58.62
64472	Inj paravertebral c/t add-on.				5.5439	$220.03	$276.51	$44.01	$55.30
64475	Inj paravertebral l/s.				6.3788	$253.16	$293.08	$50.63	$58.62
64476	Inj paravertebral l/s add-on.				5.5439	$220.03	$276.51	$44.01	$55.30
64479	Inj foramen epidural c/t.				6.3788	$253.16	$293.08	$50.63	$58.62
64480	Inj foramen epidural add-on.				6.3788	$253.16	$293.08	$50.63	$58.62
64483	Inj foramen epidural l/s.				6.3788	$253.16	$293.08	$50.63	$58.62
64484	Inj foramen epidural add-on.				6.3788	$253.16	$293.08	$50.63	$58.62
64505	N block, spenopalatine gangl.	Y	Y	Y	1.0101	$40.09	$40.09	$8.02	$8.02
64508	N block, carotid sinus s/p.	Y	Y	Y	2.2491	$89.26	$89.26	$17.85	$17.85
64510	Nblock, stellate ganglion.				6.3788	$253.16	$293.08	$50.63	$58.62
64517	Nblock inj, hypogas plxs.				2.2491	$89.26	$113.85	$17.85	$22.77
64520	Nblock, lumbar/thoracic.				6.3788	$253.16	$293.08	$50.63	$58.62
64530	Nblock inj, celiac pelus.				6.3788	$253.16	$293.08	$50.63	$58.62
64553	Implant neuroelectrodes.				234.1628	$9,293.47	$4,813.24	$1,858.69	$962.65
64555	Implant neuroelectrodes.	Y	Y	Y	2.4298	$96.44	$96.44	$19.29	$19.29
64560	Implant neuroelectrodes.	Y			56.3855	$2,237.83	$2,237.83	$447.57	$447.57
64561	Implant neuroelectrodes.				56.3855	$2,237.83	$1,373.92	$447.57	$274.78
64565	Implant neuroelectrodes.	Y	Y	Y	2.4267	$96.31	$96.31	$19.26	$19.26
64573	Implant neuroelectrodes.				234.1628	$9,293.47	$4,813.24	$1,858.69	$962.65
64575	Implant neuroelectrodes.				84.2373	$3,343.22	$1,838.11	$668.64	$367.62
64577	Implant neuroelectrodes.				84.2373	$3,343.22	$1,838.11	$668.64	$367.62

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
64580	Implant neuroelectrodes.				84.2373	$3,343.22	$1,838.11	$668.64	$367.62
64581	Implant neuroelectrodes.				84.2373	$3,343.22	$1,926.61	$668.64	$385.32
64585	Revise/remove neuroelectrode.				17.1830	$681.96	$507.48	$136.39	$101.50
64590	Insrt/redo perph n generator.				178.1307	$7,069.67	$3,757.83	$1,413.93	$751.57
64595	Revise/remove neuroreceiver.				33.9521	$1,347.49	$840.25	$269.50	$168.05
64600	Injection treatment of nerve.				12.4432	$493.85	$413.42	$98.77	$82.68
64605	Injection treatment of nerve.				12.4432	$493.85	$413.42	$98.77	$82.68
64610	Injection treatment of nerve.				12.4432	$493.85	$413.42	$98.77	$82.68
64612	Destroy nerve, face muscle.	Y	Y	Y	1.7396	$69.04	$69.04	$13.81	$13.81
64613	Destroy nerve, spine muscle.	Y	Y	Y	1.8356	$72.85	$72.85	$14.57	$14.57
64614	Destroy nerve, extrem musc.	Y	Y	Y	2.0569	$81.63	$81.63	$16.33	$16.33
64620	Injection treatment of nerve.				12.4432	$493.85	$413.42	$98.77	$82.68
64622	Destr paravertebrl nerve l/s.				12.4432	$493.85	$413.42	$98.77	$82.68
64623	Destr paravertebral n add-on.				6.3788	$253.16	$293.08	$50.63	$58.62
64626	Destr paravertebrl nerve c/t.				12.4432	$493.85	$413.42	$98.77	$82.68
64627	Destr paravertebral n add-on.				6.3788	$253.16	$293.08	$50.63	$58.62
64630	Injection treatment of nerve.				5.5439	$220.03	$280.63	$44.01	$56.13
64640	Injection treatment of nerve.	Y	Y	Y	2.8054	$111.34	$111.34	$22.27	$22.27
64650	Chemodenerv eccrine glands.	Y			2.2491	$89.26	$89.26	$17.85	$17.85
64653	Chemodenerv eccrine glands.	Y			2.2491	$89.26	$89.26	$17.85	$17.85
64680	Injection treatment of nerve.				6.3788	$253.16	$322.89	$50.63	$64.58
64681	Injection treatment of nerve.				12.4432	$493.85	$469.92	$98.77	$93.98
64702	Revise finger/toe nerve.				17.7609	$704.90	$518.95	$140.98	$103.79
64704	Revise hand/foot nerve.				17.7609	$704.90	$518.95	$140.98	$103.79
64708	Revise arm/leg nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
64712	Revision of sciatic nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
64713	Revision of arm nerve(s).				17.7609	$704.90	$575.45	$140.98	$115.09
64714	Revise low back nerve(s).				17.7609	$704.90	$575.45	$140.98	$115.09
64716	Revision of cranial nerve.				17.7609	$704.90	$607.45	$140.98	$121.49

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
64718	Revise ulnar nerve at elbow.				17.7609	$704.90	$575.45	$140.98	$115.09
64719	Revise ulnar nerve at wrist.				17.7609	$704.90	$575.45	$140.98	$115.09
64721	Carpal tunnel surgery.				17.7609	$704.90	$575.45	$140.98	$115.09
64722	Relieve pressure on nerve(s).				17.7609	$704.90	$518.95	$140.98	$103.79
64726	Release foot/toe nerve.				17.7609	$704.90	$518.95	$140.98	$103.79
64727	Internal nerve revision.				17.7609	$704.90	$518.95	$140.98	$103.79
64732	Incision of brow nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
64734	Incision of cheek nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
64736	Incision of chin nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
64738	Incision of jaw nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
64740	Incision of tongue nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
64742	Incision of facial nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
64744	Incise nerve, back of head.				17.7609	$704.90	$575.45	$140.98	$115.09
64746	Incise diaphragm nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
64761	Incision of pelvis nerve.	Y			17.7609	$704.90	$704.90	$140.98	$140.98
64763	Incise hip/thigh nerve.	Y			17.7609	$704.90	$704.90	$140.98	$140.98
64766	Incise hip/thigh nerve.	Y			33.3035	$1,321.75	$1,321.75	$264.35	$264.35
64771	Sever cranial nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
64772	Incision of spinal nerve.				17.7609	$704.90	$575.45	$140.98	$115.09
64774	Remove skin nerve lesion.				17.7609	$704.90	$575.45	$140.98	$115.09
64776	Remove digit nerve lesion.				17.7609	$704.90	$607.45	$140.98	$121.49
64778	Digit nerve surgery add-on.				17.7609	$704.90	$575.45	$140.98	$115.09
64782	Remove limb nerve lesion.				17.7609	$704.90	$607.45	$140.98	$121.49
64783	Limb nerve surgery add-on.				17.7609	$704.90	$575.45	$140.98	$115.09
64784	Remove nerve lesion.				17.7609	$704.90	$607.45	$140.98	$121.49
64786	Remove sciatic nerve lesion.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64787	Implant nerve end.				17.7609	$704.90	$575.45	$140.98	$115.09
64788	Remove skin nerve lesion.				17.7609	$704.90	$607.45	$140.98	$121.49
64790	Removal of nerve lesion.				17.7609	$704.90	$607.45	$140.98	$121.49
64792	Removal of nerve lesion.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64795	Biopsy of nerve				17.7609	$704.90	$575.45	$140.98	$115.09
64802	Remove sympathetic nerves.				17.7609	$704.90	$575.45	$140.98	$115.09
64820	Remove sympathetic nerves.	Y			17.7609	$704.90	$704.90	$140.98	$140.98

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
64821	Remove sympathetic nerves.				25.8425	$1,025.64	$827.82	$205.13	$165.56
64822	Remove sympathetic nerves.	Y			25.8425	$1,025.64	$1,025.64	$205.13	$205.13
64823	Remove sympathetic nerves.	Y			25.8425	$1,025.64	$1,025.64	$205.13	$205.13
64831	Repair of digit nerve.				33.3035	$1,321.75	$975.88	$264.35	$195.18
64832	Repair nerve add-on.				33.3035	$1,321.75	$827.38	$264.35	$165.48
64834	Repair of hand or foot nerve.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64835	Repair of hand or foot nerve.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64836	Repair of hand or foot nerve.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64837	Repair nerve add-on.				33.3035	$1,321.75	$827.38	$264.35	$165.48
64840	Repair of leg nerve.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64856	Repair/transpose nerve.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64857	Repair arm/leg nerve.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64858	Repair sciatic nerve.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64859	Nerve surgery				33.3035	$1,321.75	$827.38	$264.35	$165.48
64861	Repair of arm nerves.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64862	Repair of low back nerves.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64864	Repair of facial nerve.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64865	Repair of facial nerve.				33.3035	$1,321.75	$975.88	$264.35	$195.18
64870	Fusion of facial/other nerve.				33.3035	$1,321.75	$975.88	$264.35	$195.18
64872	Subsequent repair of nerve.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64874	Repair & revise nerve add-on.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64876	Repair nerve/shorten bone.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64885	Nerve graft, head or neck.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64886	Nerve graft, head or neck.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64890	Nerve graft, hand or foot.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64891	Nerve graft, hand or foot.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64892	Nerve graft, arm or leg.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64893	Nerve graft, arm or leg.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64895	Nerve graft, hand or foot.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64896	Nerve graft, hand or foot.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64897	Nerve graft, arm or leg.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64898	Nerve graft, arm or leg.				33.3035	$1,321.75	$915.88	$264.35	$183.18
64901	Nerve graft add-on.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64902	Nerve graft add-on.				33.3035	$1,321.75	$883.88	$264.35	$176.78

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
64905	Nerve pedicle transfer.				33.3035	$1,321.75	$883.88	$264.35	$176.78
64907	Nerve pedicle transfer.				33.3035	$1,321.75	$827.38	$264.35	$165.48
65091	Revise eye				35.5217	$1,409.79	$959.89	$281.96	$191.98
65093	Revise eye with implant.				35.5217	$1,409.79	$959.89	$281.96	$191.98
65101	Removal of eye				35.5217	$1,409.79	$959.89	$281.96	$191.98
65103	Remove eye/insert implant.				35.5217	$1,409.79	$959.89	$281.96	$191.98
65105	Remove eye/attach implant.				35.5217	$1,409.79	$1,019.89	$281.96	$203.98
65110	Removal of eye				35.5217	$1,409.79	$1,063.39	$281.96	$212.68
65112	Remove eye/revise socket.				35.5217	$1,409.79	$1,202.39	$281.96	$240.48
65114	Remove eye/revise socket.				35.5217	$1,409.79	$1,202.39	$281.96	$240.48
65125	Revise ocular implant.	Y			17.0126	$675.20	$675.20	$135.04	$135.04
65130	Insert ocular implant.				24.8502	$986.26	$748.13	$197.25	$149.63
65135	Insert ocular implant.				24.8502	$986.26	$716.13	$197.25	$143.23
65140	Attach ocular implant.				35.5217	$1,409.79	$959.89	$281.96	$191.98
65150	Revise ocular implant.				24.8502	$986.26	$716.13	$197.25	$143.23
65155	Reinsert ocular implant.				35.5217	$1,409.79	$959.89	$281.96	$191.98
65175	Removal of ocular implant.				17.0126	$675.20	$504.10	$135.04	$100.82
65205	Remove foreign body from eye.	Y	Y	Y	0.5328	$21.15	$21.15	$4.23	$4.23
65210	Remove foreign body from eye.	Y	Y	Y	0.6756	$26.81	$26.81	$5.36	$5.36
65220	Remove foreign body from eye.	Y			1.2244	$48.59	$48.59	$9.72	$9.72
65222	Remove foreign body from eye.	Y	Y	Y	0.7394	$29.35	$29.35	$5.87	$5.87
65235	Remove foreign body from eye.				14.9969	$595.20	$520.60	$119.04	$104.12
65260	Remove foreign body from eye.				16.3433	$648.63	$579.32	$129.73	$115.86
65265	Remove foreign body from eye.				26.9305	$1,068.82	$849.41	$213.76	$169.88
65270	Repair of eye wound.				17.0126	$675.20	$560.60	$135.04	$112.12
65272	Repair of eye wound.				22.9479	$910.76	$678.38	$182.15	$135.68
65275	Repair of eye wound.				22.9479	$910.76	$770.38	$182.15	$154.08
65280	Repair of eye wound.				16.3433	$648.63	$639.32	$129.73	$127.86
65285	Repair of eye wound.				36.8820	$1,463.78	$1,046.89	$292.76	$209.38
65286	Repair of eye wound.	Y	Y		5.9800	$237.33	$237.33	$47.47	$47.47
65290	Repair of eye socket wound.				21.2885	$844.90	$677.45	$168.98	$135.49
65400	Removal of eye lesion.				14.9969	$595.20	$464.10	$119.04	$92.82

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
65410	Biopsy of cornea.				14.9969	$595.20	$520.60	$119.04	$104.12
65420	Removal of eye lesion.				14.9969	$595.20	$520.60	$119.04	$104.12
65426	Removal of eye lesion.				22.9479	$910.76	$813.88	$182.15	$162.78
65430	Corneal smear	Y	Y	Y	1.0593	$42.04	$42.04	$8.41	$8.41
65435	Curette/treat cornea.	Y	Y	Y	0.8260	$32.78	$32.78	$6.56	$6.56
65436	Curette/treat cornea.	Y			14.9969	$595.20	$595.20	$119.04	$119.04
65450	Treatment of corneal lesion.	Y			2.1934	$87.05	$87.05	$17.41	$17.41
65600	Revision of cornea.	Y	Y	Y	4.1704	$165.51	$165.51	$33.10	$33.10
65710	Corneal transplant.				37.9446	$1,505.95	$1,250.47	$301.19	$250.09
65730	Corneal transplant.				37.9446	$1,505.95	$1,250.47	$301.19	$250.09
65750	Corneal transplant.				37.9446	$1,505.95	$1,250.47	$301.19	$250.09
65755	Corneal transplant.				37.9446	$1,505.95	$1,250.47	$301.19	$250.09
65770	Revise cornea with implant.				50.6347	$2,009.59	$1,502.30	$401.92	$300.46
65772	Correction of astigmatism.				14.9969	$595.20	$612.60	$119.04	$122.52
65775	Correction of astigmatism.				14.9969	$595.20	$612.60	$119.04	$122.52
65780	Ocular reconst, transplant.				37.9446	$1,505.95	$1,111.47	$301.19	$222.29
65781	Ocular reconst, transplant.				37.9446	$1,505.95	$1,111.47	$301.19	$222.29
65782	Ocular reconst, transplant.				37.9446	$1,505.95	$1,111.47	$301.19	$222.29
65800	Drainage of eye				14.9969	$595.20	$464.10	$119.04	$92.82
65805	Drainage of eye				14.9969	$595.20	$464.10	$119.04	$92.82
65810	Drainage of eye				22.9479	$910.76	$710.38	$182.15	$142.08
65815	Drainage of eye				22.9479	$910.76	$678.38	$182.15	$135.68
65820	Relieve inner eye pressure.				5.9800	$237.33	$285.17	$47.47	$57.03
65850	Incision of eye				22.9479	$910.76	$770.38	$182.15	$154.08
65855	Laser surgery of eye.	Y	Y	Y	3.4882	$138.44	$138.44	$27.69	$27.69
65860	Incise inner eye adhesions.	Y	Y	Y	3.2701	$129.78	$129.78	$25.96	$25.96
65865	Incise inner eye adhesions.				14.9969	$595.20	$464.10	$119.04	$92.82
65870	Incise inner eye adhesions.				22.9479	$910.76	$770.38	$182.15	$154.08
65875	Incise inner eye adhesions.				22.9479	$910.76	$770.38	$182.15	$154.08
65880	Incise inner eye adhesions.				14.9969	$595.20	$612.60	$119.04	$122.52
65900	Remove eye lesion.				14.9969	$595.20	$656.10	$119.04	$131.22
65920	Remove implant of eye.				22.9479	$910.76	$952.88	$182.15	$190.58
65930	Remove blood clot from eye.				22.9479	$910.76	$813.88	$182.15	$162.78
66020	Injection treatment of eye.				14.9969	$595.20	$464.10	$119.04	$92.82
66030	Injection treatment of eye.				5.9800	$237.33	$285.17	$47.47	$57.03
66130	Remove eye lesion.				22.9479	$910.76	$952.88	$182.15	$190.58
66150	Glaucoma surgery.				22.9479	$910.76	$770.38	$182.15	$154.08

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
66155	Glaucoma surgery.				22.9479	$910.76	$770.38	$182.15	$154.08
66160	Glaucoma surgery.				22.9479	$910.76	$678.38	$182.15	$135.68
66165	Glaucoma surgery.				22.9479	$910.76	$770.38	$182.15	$154.08
66170	Glaucoma surgery.				22.9479	$910.76	$770.38	$182.15	$154.08
66172	Incision of eye				22.9479	$910.76	$770.38	$182.15	$154.08
66180	Implant eye shunt.				37.3057	$1,480.59	$1,098.80	$296.12	$219.76
66185	Revise eye shunt.				37.3057	$1,480.59	$963.30	$296.12	$192.66
66220	Repair eye lesion.				36.8820	$1,463.78	$986.89	$292.76	$197.38
66225	Repair/graft eye lesion.				37.3057	$1,480.59	$1,055.30	$296.12	$211.06
66250	Follow-up surgery of eye.				14.9969	$595.20	$520.60	$119.04	$104.12
66500	Incision of iris				5.9800	$237.33	$285.17	$47.47	$57.03
66505	Incision of iris				5.9800	$237.33	$285.17	$47.47	$57.03
66600	Remove iris and lesion.				22.9479	$910.76	$710.38	$182.15	$142.08
66605	Removal of iris				22.9479	$910.76	$710.38	$182.15	$142.08
66625	Removal of iris				5.9800	$237.33	$302.70	$47.47	$60.54
66630	Removal of iris				22.9479	$910.76	$710.38	$182.15	$142.08
66635	Removal of iris				22.9479	$910.76	$710.38	$182.15	$142.08
66680	Repair iris & ciliary body.				22.9479	$910.76	$710.38	$182.15	$142.08
66682	Repair iris & ciliary body.				22.9479	$910.76	$678.38	$182.15	$135.68
66700	Destruction, ciliary body.				14.9969	$595.20	$520.60	$119.04	$104.12
66710	Ciliary transsleral therapy.				14.9969	$595.20	$520.60	$119.04	$104.12
66711	Ciliary endoscopic ablation.				14.9969	$595.20	$520.60	$119.04	$104.12
66720	Destruction, ciliary body.				14.9969	$595.20	$520.60	$119.04	$104.12
66740	Destruction, ciliary body.				22.9479	$910.76	$678.38	$182.15	$135.68
66761	Revision of iris	Y	Y	Y	4.6821	$185.82	$185.82	$37.16	$37.16
66762	Revision of iris	Y	Y	Y	4.7458	$188.35	$188.35	$37.67	$37.67
66770	Removal of inner eye lesion.	Y	Y	Y	5.1266	$203.46	$203.46	$40.69	$40.69
66820	Incision, secondary cataract.	Y			5.9800	$237.33	$237.33	$47.47	$47.47
66821	After cataract laser surgery.				5.1266	$203.46	$259.51	$40.69	$51.90
66825	Reposition intraocular lens.				22.9479	$910.76	$770.38	$182.15	$154.08
66830	Removal of lens lesion.				5.9800	$237.33	$302.70	$47.47	$60.54
66840	Removal of lens material.				14.5427	$577.17	$603.59	$115.43	$120.72
66850	Removal of lens material.				28.5043	$1,131.28	$1,063.14	$226.26	$212.63
66852	Removal of lens material.				28.5043	$1,131.28	$880.64	$226.26	$176.13
66920	Extraction of lens.				28.5043	$1,131.28	$880.64	$226.26	$176.13
66930	Extraction of lens.				28.5043	$1,131.28	$924.14	$226.26	$184.83

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
66940	Extraction of lens.				14.5427	$577.17	$647.09	$115.43	$129.42
66982	Cataract surgery, complex.				23.5664	$935.31	$954.15	$187.06	$190.83
66983	Cataract surg w/ iol, 1 stage.				23.5664	$935.31	$954.15	$187.06	$190.83
66984	Cataract surg w/ iol, 1 stage.				23.5664	$935.31	$954.15	$187.06	$190.83
66985	Insert lens prosthesis.				23.5664	$935.31	$880.65	$187.06	$176.13
66986	Exchange lens prosthesis.				23.5664	$935.31	$880.65	$187.06	$176.13
67005	Partial removal of eye fluid.				26.9305	$1,068.82	$849.41	$213.76	$169.88
67010	Partial removal of eye fluid.				26.9305	$1,068.82	$849.41	$213.76	$169.88
67015	Release of eye fluid.				26.9305	$1,068.82	$700.91	$213.76	$140.18
67025	Replace eye fluid.				26.9305	$1,068.82	$700.91	$213.76	$140.18
67027	Implant eye drug system.				36.8820	$1,463.78	$1,046.89	$292.76	$209.38
67028	Injection eye drug.	Y	Y	Y	2.1499	$85.32	$85.32	$17.06	$17.06
67030	Incise inner eye strands.				16.3433	$648.63	$490.82	$129.73	$98.16
67031	Laser surgery, eye strands.				5.1266	$203.46	$259.51	$40.69	$51.90
67036	Removal of inner eye fluid.				36.8820	$1,463.78	$1,046.89	$292.76	$209.38
67038	Strip retinal membrane.				36.8820	$1,463.78	$1,090.39	$292.76	$218.08
67039	Laser treatment of retina.				36.8820	$1,463.78	$1,229.39	$292.76	$245.88
67040	Laser treatment of retina.				36.8820	$1,463.78	$1,229.39	$292.76	$245.88
67101	Repair detached retina.	Y	Y	Y	7.7847	$308.96	$308.96	$61.79	$61.79
67105	Repair detached retina.	Y	Y		5.0285	$199.57	$199.57	$39.91	$39.91
67107	Repair detached retina.				36.8820	$1,463.78	$1,090.39	$292.76	$218.08
67108	Repair detached retina.				36.8820	$1,463.78	$1,229.39	$292.76	$245.88
67110	Repair detached retina.	Y	Y	Y	8.4635	$335.90	$335.90	$67.18	$67.18
67112	Rerepair detached retina.				36.8820	$1,463.78	$1,229.39	$292.76	$245.88
67115	Release encircling material.				16.3433	$648.63	$547.32	$129.73	$109.46
67120	Remove eye implant material.				16.3433	$648.63	$547.32	$129.73	$109.46
67121	Remove eye implant material.				26.9305	$1,068.82	$757.41	$213.76	$151.48
67141	Treatment of retina.				4.0750	$161.73	$206.27	$32.35	$41.25
67145	Treatment of retina.	Y	Y	Y	4.8836	$193.82	$193.82	$38.76	$38.76
67208	Treatment of retinal lesion.	Y	Y	Y	5.2064	$206.63	$206.63	$41.33	$41.33
67210	Treatment of retinal lesion.	Y	Y		5.0285	$199.57	$199.57	$39.91	$39.91
67218	Treatment of retinal lesion.				16.3433	$648.63	$682.82	$129.73	$136.56
67220	Treatment of choroid lesion.	Y	Y		4.0750	$161.73	$161.73	$32.35	$32.35

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
67221	Ocular photodynamic ther.	Y	Y	Y	3.3107	$131.39	$131.39	$26.28	$26.28
67225	Eye photodynamic ther add-on.	Y	Y	Y	0.2131	$8.46	$8.46	$1.69	$1.69
67227	Treatment of retinal lesion.				26.9305	$1,068.82	$700.91	$213.76	$140.18
67228	Treatment of retinal lesion.	Y	Y		5.0285	$199.57	$199.57	$39.91	$39.91
67250	Reinforce eye wall.				17.0126	$675.20	$592.60	$135.04	$118.52
67255	Reinforce/graft eye wall.				26.9305	$1,068.82	$789.41	$213.76	$157.88
67311	Revise eye muscle.				21.2885	$844.90	$677.45	$168.98	$135.49
67312	Revise two eye muscles.				21.2885	$844.90	$737.45	$168.98	$147.49
67314	Revise eye muscle.				21.2885	$844.90	$737.45	$168.98	$147.49
67316	Revise two eye muscles.				21.2885	$844.90	$737.45	$168.98	$147.49
67318	Revise eye muscle(s).				21.2885	$844.90	$737.45	$168.98	$147.49
67320	Revise eye muscle(s) add-on.				21.2885	$844.90	$737.45	$168.98	$147.49
67331	Eye surgery follow-up add-on.				21.2885	$844.90	$737.45	$168.98	$147.49
67332	Rerevise eye muscles add-on.				21.2885	$844.90	$737.45	$168.98	$147.49
67334	Revise eye muscle w/suture.				21.2885	$844.90	$737.45	$168.98	$147.49
67335	Eye suture during surgery.				21.2885	$844.90	$737.45	$168.98	$147.49
67340	Revise eye muscle add-on.				21.2885	$844.90	$737.45	$168.98	$147.49
67343	Release eye tissue.				21.2885	$844.90	$919.95	$168.98	$183.99
67345	Destroy nerve of eye muscle.	Y	Y	Y	2.1183	$84.07	$84.07	$16.81	$16.81
67350	Biopsy eye muscle.				13.9509	$553.68	$443.34	$110.74	$88.67
67400	Explore/biopsy eye socket.				24.8502	$986.26	$748.13	$197.25	$149.63
67405	Explore/drain eye socket.				24.8502	$986.26	$808.13	$197.25	$161.63
67412	Explore/treat eye socket.				24.8502	$986.26	$851.63	$197.25	$170.33
67413	Explore/treat eye socket.				24.8502	$986.26	$851.63	$197.25	$170.33
67414	Explr/decompress eye socket.	Y			35.5217	$1,409.79	$1,409.79	$281.96	$281.96
67415	Aspiration, orbital contents.				17.0126	$675.20	$504.10	$135.04	$100.82
67420	Explore/treat eye socket.				35.5217	$1,409.79	$1,063.39	$281.96	$212.68
67430	Explore/treat eye socket.				35.5217	$1,409.79	$1,063.39	$281.96	$212.68
67440	Explore/drain eye socket.				35.5217	$1,409.79	$1,063.39	$281.96	$212.68
67445	Explr/decompress eye socket.				35.5217	$1,409.79	$1,063.39	$281.96	$212.68

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
67450	Explore/biopsy eye socket.				35.5217	$1,409.79	$1,063.39	$281.96	$212.68
67500	Inject/treat eye socket.	Y			2.1934	$87.05	$87.05	$17.41	$17.41
67505	Inject/treat eye socket.	Y			2.8099	$111.52	$111.52	$22.30	$22.30
67515	Inject/treat eye socket.	Y	Y	Y	0.6151	$24.41	$24.41	$4.88	$4.88
67550	Insert eye socket implant.				35.5217	$1,409.79	$1,019.89	$281.96	$203.98
67560	Revise eye socket implant.				24.8502	$986.26	$716.13	$197.25	$143.23
67570	Decompress optic nerve.				35.5217	$1,409.79	$1,019.89	$281.96	$203.98
67700	Drainage of eyelid abscess.	Y	Y		2.8099	$111.52	$111.52	$22.30	$22.30
67710	Incision of eyelid.	Y	Y	Y	4.0013	$158.80	$158.80	$31.76	$31.76
67715	Incision of eyelid fold.				17.0126	$675.20	$504.10	$135.04	$100.82
67800	Remove eyelid lesion.	Y	Y	Y	1.3373	$53.08	$53.08	$10.62	$10.62
67801	Remove eyelid lesions.	Y	Y	Y	1.6194	$64.27	$64.27	$12.85	$12.85
67805	Remove eyelid lesions.	Y	Y	Y	2.0923	$83.04	$83.04	$16.61	$16.61
67808	Remove eyelid lesion(s).				17.0126	$675.20	$560.60	$135.04	$112.12
67810	Biopsy of eyelid	Y	Y		2.8099	$111.52	$111.52	$22.30	$22.30
67820	Revise eyelashes.	Y	Y	Y	0.4905	$19.47	$19.47	$3.89	$3.89
67825	Revise eyelashes.	Y	Y	Y	1.3893	$55.14	$55.14	$11.03	$11.03
67830	Revise eyelashes.				6.9354	$275.25	$351.07	$55.05	$70.21
67835	Revise eyelashes.				17.0126	$675.20	$560.60	$135.04	$112.12
67840	Remove eyelid lesion.	Y	Y	Y	4.1405	$164.33	$164.33	$32.87	$32.87
67850	Treat eyelid lesion.	Y	Y	Y	2.9051	$115.30	$115.30	$23.06	$23.06
67875	Closure of eyelid by suture.	Y			6.9354	$275.25	$275.25	$55.05	$55.05
67880	Revision of eyelid.				14.9969	$595.20	$552.60	$119.04	$110.52
67882	Revision of eyelid.				17.0126	$675.20	$592.60	$135.04	$118.52
67900	Repair brow defect.				17.0126	$675.20	$652.60	$135.04	$130.52
67901	Repair eyelid defect.				17.0126	$675.20	$696.10	$135.04	$139.22
67902	Repair eyelid defect.				17.0126	$675.20	$696.10	$135.04	$139.22
67903	Repair eyelid defect.				17.0126	$675.20	$652.60	$135.04	$130.52
67904	Repair eyelid defect.				17.0126	$675.20	$652.60	$135.04	$130.52
67906	Repair eyelid defect.				17.0126	$675.20	$696.10	$135.04	$139.22
67908	Repair eyelid defect.				17.0126	$675.20	$652.60	$135.04	$130.52
67909	Revise eyelid defect.				17.0126	$675.20	$652.60	$135.04	$130.52
67911	Revise eyelid defect.				17.0126	$675.20	$592.60	$135.04	$118.52

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
67912	Correction eyelid w/implant.				17.0126	$675.20	$592.60	$135.04	$118.52
67914	Repair eyelid defect.				17.0126	$675.20	$592.60	$135.04	$118.52
67915	Repair eyelid defect.	Y	Y	Y	4.5979	$182.48	$182.48	$36.50	$36.50
67916	Repair eyelid defect.				17.0126	$675.20	$652.60	$135.04	$130.52
67917	Repair eyelid defect.				17.0126	$675.20	$652.60	$135.04	$130.52
67921	Repair eyelid defect.				17.0126	$675.20	$592.60	$135.04	$118.52
67922	Repair eyelid defect.	Y	Y	Y	4.5261	$179.63	$179.63	$35.93	$35.93
67923	Repair eyelid defect.				17.0126	$675.20	$652.60	$135.04	$130.52
67924	Repair eyelid defect.				17.0126	$675.20	$652.60	$135.04	$130.52
67930	Repair eyelid wound.	Y	Y	Y	4.4580	$176.93	$176.93	$35.39	$35.39
67935	Repair eyelid wound.				17.0126	$675.20	$560.60	$135.04	$112.12
67938	Remove eyelid foreign body.	Y	Y		1.2244	$48.59	$48.59	$9.72	$9.72
67950	Revision of eyelid.				17.0126	$675.20	$560.60	$135.04	$112.12
67961	Revision of eyelid.				17.0126	$675.20	$592.60	$135.04	$118.52
67966	Revision of eyelid.				17.0126	$675.20	$592.60	$135.04	$118.52
67971	Reconstruction of eyelid.				24.8502	$986.26	$748.13	$197.25	$149.63
67973	Reconstruction of eyelid.				24.8502	$986.26	$748.13	$197.25	$149.63
67974	Reconstruction of eyelid.				24.8502	$986.26	$748.13	$197.25	$149.63
67975	Reconstruction of eyelid.				17.0126	$675.20	$592.60	$135.04	$118.52
68020	Incise/drain eyelid lining.	Y	Y	Y	1.1738	$46.59	$46.59	$9.32	$9.32
68040	Treatment of eyelid lesions.	Y	Y	Y	0.5826	$23.12	$23.12	$4.62	$4.62
68100	Biopsy of eyelid lining.	Y	Y	Y	2.4727	$98.14	$98.14	$19.63	$19.63
68110	Remove eyelid lining lesion.	Y	Y	Y	3.1702	$125.82	$125.82	$25.16	$25.16
68115	Remove eyelid lining lesion.				17.0126	$675.20	$560.60	$135.04	$112.12
68130	Remove eyelid lining lesion.				14.9969	$595.20	$520.60	$119.04	$104.12
68135	Remove eyelid lining lesion.	Y	Y	Y	1.5122	$60.01	$60.01	$12.00	$12.00
68200	Treat eyelid by injection.	Y	Y	Y	0.4396	$17.45	$17.45	$3.49	$3.49
68320	Revise/graft eyelid lining.				17.0126	$675.20	$652.60	$135.04	$130.52
68325	Revise/graft eyelid lining.				24.8502	$986.26	$808.13	$197.25	$161.63
68326	Revise/graft eyelid lining.				24.8502	$986.26	$808.13	$197.25	$161.63
68328	Revise/graft eyelid lining.				24.8502	$986.26	$808.13	$197.25	$161.63
68330	Revise eyelid lining.				22.9479	$910.76	$770.38	$182.15	$154.08
68335	Revise/graft eyelid lining.				24.8502	$986.26	$808.13	$197.25	$161.63
68340	Separate eyelid adhesions.				17.0126	$675.20	$652.60	$135.04	$130.52

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 copayment without 50/50 transition	CY 08 copayment with 50/50 transition
68360	Revise eyelid lining.				22.9479	$910.76	$678.38	$182.15	$135.68
68362	Revise eyelid lining.				22.9479	$910.76	$678.38	$182.15	$135.68
68371	Harvest eye tissue, alograft.				14.9969	$595.20	$520.60	$119.04	$104.12
68400	Incise/drain tear gland.	Y	Y		2.8099	$111.52	$111.52	$22.30	$22.30
68420	Incise/drain tear sac.	Y	Y	Y	4.7254	$187.54	$187.54	$37.51	$37.51
68440	Incise tear duct opening.	Y	Y	Y	1.4355	$56.97	$56.97	$11.39	$11.39
68500	Removal of tear gland.				24.8502	$986.26	$748.13	$197.25	$149.63
68505	Partial removal, tear gland.				24.8502	$986.26	$748.13	$197.25	$149.63
68510	Biopsy of tear gland.				17.0126	$675.20	$504.10	$135.04	$100.82
68520	Removal of tear sac.				24.8502	$986.26	$748.13	$197.25	$149.63
68525	Biopsy of tear sac.				17.0126	$675.20	$504.10	$135.04	$100.82
68530	Clearance of tear duct.	Y	Y	Y	6.0445	$239.89	$239.89	$47.98	$47.98
68540	Remove tear gland lesion.				24.8502	$986.26	$748.13	$197.25	$149.63
68550	Remove tear gland lesion.				24.8502	$986.26	$748.13	$197.25	$149.63
68700	Repair tear ducts.				24.8502	$986.26	$716.13	$197.25	$143.23
68705	Revise tear duct opening.	Y	Y		2.8099	$111.52	$111.52	$22.30	$22.30
68720	Create tear sac drain.				24.8502	$986.26	$808.13	$197.25	$161.63
68745	Create tear duct drain.				24.8502	$986.26	$808.13	$197.25	$161.63
68750	Create tear duct drain.				24.8502	$986.26	$808.13	$197.25	$161.63
68760	Close tear duct opening.	Y	Y		2.1934	$87.05	$87.05	$17.41	$17.41
68761	Close tear duct opening.	Y	Y	Y	1.8117	$71.90	$71.90	$14.38	$14.38
68770	Close tear system fistula.				17.0126	$675.20	$652.60	$135.04	$130.52
68801	Dilate tear duct opening.	Y	Y		1.2244	$48.59	$48.59	$9.72	$9.72
68810	Probe nasolacrimal duct.				2.1934	$87.05	$111.03	$17.41	$22.21
68811	Probe nasolacrimal duct.				17.0126	$675.20	$560.60	$135.04	$112.12
68815	Probe nasolacrimal duct.				17.0126	$675.20	$560.60	$135.04	$112.12
68840	Explore/irrigate tear ducts.	Y	Y		1.2244	$48.59	$48.59	$9.72	$9.72
69000	Drain external ear lesion.	Y	Y		1.4821	$58.82	$58.82	$11.76	$11.76
69005	Drain external ear lesion.	Y	Y	Y	2.4802	$98.44	$98.44	$19.69	$19.69
69020	Drain outer ear canal lesion.	Y	Y		1.4821	$58.82	$58.82	$11.76	$11.76
69100	Biopsy of external ear.	Y	Y	Y	1.5436	$61.26	$61.26	$12.25	$12.25
69105	Biopsy of external ear canal.	Y	Y	Y	2.1216	$84.20	$84.20	$16.84	$16.84

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
69110	Remove external ear, partial.				14.9563	$593.59	$463.29	$118.72	$92.66
69120	Removal of external ear.				23.1564	$919.03	$682.52	$183.81	$136.50
69140	Remove ear canal lesion(s).				23.1564	$919.03	$682.52	$183.81	$136.50
69145	Remove ear canal lesion(s).				14.9563	$593.59	$519.79	$118.72	$103.96
69150	Extensive ear canal surgery.				7.7261	$306.63	$391.09	$61.33	$78.22
69200	Clear outer ear canal.	Y	Y		0.6211	$24.65	$24.65	$4.93	$4.93
69205	Clear outer ear canal.				19.9760	$792.81	$562.90	$158.56	$112.58
69210	Remove impacted ear wax.	Y	Y	Y	0.5077	$20.15	$20.15	$4.03	$4.03
69220	Clean out mastoid cavity.	Y	Y		0.8076	$32.05	$32.05	$6.41	$6.41
69222	Clean out mastoid cavity.	Y	Y	Y	3.3054	$131.19	$131.19	$26.24	$26.24
69300	Revise external ear.				23.1564	$919.03	$714.52	$183.81	$142.90
69310	Rebuild outer ear canal.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
69320	Rebuild outer ear canal.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69400	Inflate middle ear canal.	Y	Y	Y	2.1026	$83.45	$83.45	$16.69	$16.69
69401	Inflate middle ear canal.	Y	Y	Y	1.1906	$47.25	$47.25	$9.45	$9.45
69405	Catheterize middle ear canal.	Y	Y	Y	3.0530	$121.17	$121.17	$24.23	$24.23
69420	Incision of eardrum.	Y	Y		2.3768	$94.33	$94.33	$18.87	$18.87
69421	Incision of eardrum.				16.4494	$652.85	$581.42	$130.57	$116.28
69424	Remove ventilating tube.	Y	Y	Y	1.9136	$75.95	$75.95	$15.19	$15.19
69433	Create eardrum opening.	Y	Y	Y	2.7076	$107.46	$107.46	$21.49	$21.49
69436	Create eardrum opening.				16.4494	$652.85	$581.42	$130.57	$116.28
69440	Exploration of middle ear.				23.1564	$919.03	$714.52	$183.81	$142.90
69450	Eardrum revision.				37.7719	$1,499.09	$916.05	$299.82	$183.21
69501	Mastoidectomy				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69502	Mastoidectomy				23.1564	$919.03	$957.02	$183.81	$191.40
69505	Remove mastoid structures.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69511	Extensive mastoid surgery.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69530	Extensive mastoid surgery.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69540	Remove ear lesion.	Y	Y	Y	3.2334	$128.33	$128.33	$25.67	$25.67
69550	Remove ear lesion.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69552	Remove ear lesion.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69601	Mastoid surgery revision.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69602	Mastoid surgery revision.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
69603	Mastoid surgery revision.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69604	Mastoid surgery revision.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69605	Mastoid surgery revision.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69610	Repair of eardrum.	Y	Y	Y	4.4163	$175.28	$175.28	$35.06	$35.06
69620	Repair of eardrum.				23.1564	$919.03	$682.52	$183.81	$136.50
69631	Repair eardrum structures.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69632	Rebuild eardrum structures.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69633	Rebuild eardrum structures.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69635	Repair eardrum structures.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69636	Rebuild eardrum structures.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69637	Rebuild eardrum structures.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69641	Revise middle ear & mastoid.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69642	Revise middle ear & mastoid.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69643	Revise middle ear & mastoid.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69644	Revise middle ear & mastoid.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69645	Revise middle ear & mastoid.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69646	Revise middle ear & mastoid.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69650	Release middle ear bone.				23.1564	$919.03	$957.02	$183.81	$191.40
69660	Revise middle ear bone.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69661	Revise middle ear bone.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69662	Revise middle ear bone.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69666	Repair middle ear structures.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
69667	Repair middle ear structures.				37.7719	$1,499.09	$1,064.55	$299.82	$212.91
69670	Remove mastoid air cells.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
69676	Remove middle ear nerve.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
69700	Close mastoid fistula.				37.7719	$1,499.09	$1,004.55	$299.82	$200.91
69711	Remove/repair hearing aid.				37.7719	$1,499.09	$916.05	$299.82	$183.21
69714	Implant temple bone w/stimul.				37.7719	$1,499.09	$1,419.05	$299.82	$283.81
69715	Temple bne implnt w/stimulat.				37.7719	$1,499.09	$1,419.05	$299.82	$283.81
69717	Temple bone implant revision.				37.7719	$1,499.09	$1,419.05	$299.82	$283.81
69718	Revise temple bone implant.				37.7719	$1,499.09	$1,419.05	$299.82	$283.81

ADDENDUM BB.—PROPOSED LIST OF MEDICARE APPROVED ASC PROCEDURES FOR CY 2008 WITH ADDITIONS AND PAYMENT RATES—Continued

HCPCS	Short Description	New 2008 ASC approved procedure	Designated as office based	Payment capped at MPFS rate	CY 08 ASC relative payment weight	CY 08 payment without 50/50 transition	CY 08 payment with 50/50 transition	CY 08 co-payment without 50/50 transition	CY 08 co-payment with 50/50 transition
69720	Release facial nerve.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69740	Repair facial nerve.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69745	Repair facial nerve.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69801	Incise inner ear				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69802	Incise inner ear				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69805	Explore inner ear.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69806	Explore inner ear.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69820	Establish inner ear window.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69840	Revise inner ear window.				37.7719	$1,499.09	$1,108.05	$299.82	$221.61
69905	Remove inner ear.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69910	Remove inner ear & mastoid.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69915	Incise inner ear nerve.				37.7719	$1,499.09	$1,247.05	$299.82	$249.41
69930	Implant cochlear device.				406.8232	$16,146.03	$8,570.52	$3,229.21	$1,714.10
G0104	CA screen;flexi sigmoidscope.	Y	Y		1.7292	$68.63	$68.63	$13.73	$13.73
G0105	Colorectal scrn; hi risk ind.				7.8134	$310.10	$378.05	$62.02	$75.61
G0121	Colon ca scrn; not high rsk.				7.8134	$310.10	$378.05	$62.02	$75.61
G0127	Trim nail(s)	Y	Y		0.2665	$10.58	$10.58	$2.12	$2.12
G0186	Dstry eye lesn,fdr vssl tech.	Y	Y		4.0750	$161.73	$161.73	$32.35	$32.35
G0260	Inj for sacroiliac jt anesth.				5.5439	$220.03	$276.51	$44.01	$55.30
G0268	Removal of impacted wax md.	Y	Y		0.5409	$21.47	$21.47	$4.29	$4.29
G0364	Bone marrow aspirate & biops.	Y	Y		0.1293	$5.13	$5.13	$1.03	$1.03

ADDENDUM CC.—PROPOSED LIST OF PROCEDURES FOR CY 2008 SUBJECT TO PAYMENT LIMITATION AT THE MPFS NONFACILITY AMOUNT

HCPCS	Short Description
10021	Fna w/o image
10040	Acne surgery
10060	Drainage of skin abscess
10061	Drainage of skin abscess
10080	Drainage of pilonidal cyst
10081	Drainage of pilonidal cyst
10120	Remove foreign body
10140	Drainage of hematoma/fluid
10160	Puncture drainage of lesion
11000	Debride infected skin
11001	Debride infected skin add-on
11040	Debride skin, partial
11041	Debride skin, full
11055	Trim skin lesion
11056	Trim skin lesions, 2 to 4

ADDENDUM CC.—PROPOSED LIST OF PROCEDURES FOR CY 2008 SUBJECT TO PAYMENT LIMITATION AT THE MPFS NONFACILITY AMOUNT—Continued

HCPCS	Short Description
11057	Trim skin lesions, over 4
11100	Biopsy, skin lesion
11101	Biopsy, skin add-on
11200	Removal of skin tags
11201	Remove skin tags add-on
11300	Shave skin lesion
11301	Shave skin lesion
11302	Shave skin lesion
11303	Shave skin lesion
11305	Shave skin lesion
11306	Shave skin lesion
11307	Shave skin lesion
11308	Shave skin lesion
11310	Shave skin lesion
11311	Shave skin lesion

ADDENDUM CC.—PROPOSED LIST OF PROCEDURES FOR CY 2008 SUBJECT TO PAYMENT LIMITATION AT THE MPFS NONFACILITY AMOUNT—Continued

HCPCS	Short Description
11312	Shave skin lesion
11313	Shave skin lesion
11400	Exc tr-ext b9+marg 0.5 < cm
11401	Exc tr-ext b9+marg 0.6-1 cm
11402	Exc tr-ext b9+marg 1.1-2 cm
11403	Exc tr-ext b9+marg 2.1-3 cm
11420	Exc h-f-nk-sp b9+marg 0.5 >
11421	Exc h-f-nk-sp b9+marg 0.6-1
11422	Exc h-f-nk-sp b9+marg 1.1-2
11423	Exc h-f-nk-sp b9+marg 2.1-3
11440	Exc face-mm b9+marg 0.5 < cm
11441	Exc face-mm b9+marg 0.6-1 cm
11442	Exc face-mm b9+marg 1.1-2 cm
11443	Exc face-mm b9+marg 2.1-3 cm
11600	Exc tr-ext mlg+marg 0.5 < cm

ADDENDUM CC.—PROPOSED LIST OF PROCEDURES FOR CY 2008 SUBJECT TO PAYMENT LIMITATION AT THE MPFS NONFACILITY AMOUNT—Continued

HCPCS	Short Description
11601	Exc tr-ext mlg+marg 0.6-1 cm
11602	Exc tr-ext mlg+marg 1.1-2 cm
11603	Exc tr-ext mlg+marg 2.1-3 cm
11620	Exc h-f-nk-sp mlg+marg 0.5 >
11621	Exc h-f-nk-sp mlg+marg 0.6-1
11622	Exc h-f-nk-sp mlg+marg 1.1-2
11623	Exc h-f-nk-sp mlg+marg 2.1-3
11640	Exc face-mm malig+marg 0.5
11641	Exc face-mm malig+marg 0.6-1
11642	Exc face-mm malig+marg 1.1-2
11643	Exc face-mm malig+marg 2.1-3
11719	Trim nail(s)
11720	Debride nail, 1-5
11721	Debride nail, 6 or more
11730	Removal of nail plate
11732	Remove nail plate, add-on
11740	Drain blood from under nail
11750	Removal of nail bed
11752	Remove nail bed/finger tip
11755	Biopsy, nail unit
11762	Reconstruction of nail bed
11765	Excision of nail fold, toe
11900	Injection into skin lesions
11901	Added skin lesions injection
11920	Correct skin color defects
11921	Correct skin color defects
11922	Correct skin color defects
11950	Therapy for contour defects
11951	Therapy for contour defects
11952	Therapy for contour defects
11954	Therapy for contour defects
11976	Removal of contraceptive cap
11980	Implant hormone pellet(s)
11981	Insert drug implant device
11982	Remove drug implant device
11983	Remove/insert drug implant
12001	Repair superficial wound(s)
12002	Repair superficial wound(s)
12004	Repair superficial wound(s)
12011	Repair superficial wound(s)
12013	Repair superficial wound(s)
12014	Repair superficial wound(s)
12031	Layer closure of wound(s)
12032	Layer closure of wound(s)
12041	Layer closure of wound(s)
12042	Layer closure of wound(s)
12051	Layer closure of wound(s)
12052	Layer closure of wound(s)
12053	Layer closure of wound(s)
13133	Repair wound/lesion add-on
15340	Apply cult skin substitute
15780	Abrasion treatment of skin
15781	Abrasion treatment of skin
15782	Abrasion treatment of skin
15783	Abrasion treatment of skin
15786	Abrasion, lesion, single
15787	Abrasion, lesions, add-on
15788	Chemical peel, face, epiderm
15789	Chemical peel, face, dermal
15792	Chemical peel, nonfacial
15793	Chemical peel, nonfacial
15851	Removal of sutures
16000	Initial treatment of burn(s)
16020	Dress/debrid p-thick burn, s
17000	Destroy benign/premlg lesion
17003	Destroy lesions, 2-14
17004	Destroy lesions, 15 or more

ADDENDUM CC.—PROPOSED LIST OF PROCEDURES FOR CY 2008 SUBJECT TO PAYMENT LIMITATION AT THE MPFS NONFACILITY AMOUNT—Continued

HCPCS	Short Description
17106	Destruction of skin lesions
17107	Destruction of skin lesions
17108	Destruction of skin lesions
17110	Destruct lesion, 1-14
17111	Destruct lesion, 15 or more
17250	Chemical cautery, tissue
17260	Destruction of skin lesions
17261	Destruction of skin lesions
17262	Destruction of skin lesions
17263	Destruction of skin lesions
17264	Destruction of skin lesions
17266	Destruction of skin lesions
17270	Destruction of skin lesions
17271	Destruction of skin lesions
17272	Destruction of skin lesions
17273	Destruction of skin lesions
17274	Destruction of skin lesions
17276	Destruction of skin lesions
17280	Destruction of skin lesions
17281	Destruction of skin lesions
17282	Destruction of skin lesions
17283	Destruction of skin lesions
17284	Destruction of skin lesions
17286	Destruction of skin lesions
17304	1 stage mohs, up to 5 spec
17305	2 stage mohs, up to 5 spec
17306	3 stage mohs, up to 5 spec
17307	Mohs addl stage up to 5 spec
17310	Mohs any stage > 5 spec each
17340	Cryotherapy of skin
17360	Skin peel therapy
17380	Hair removal by electrolysis
19000	Drainage of breast lesion
19001	Drain breast lesion add-on
20000	Incision of abscess
20500	Injection of sinus tract
20520	Removal of foreign body
20526	Ther injection, carp tunnel
20550	Inj tendon sheath/ligament
20551	Inj tendon origin/insertion
20552	Inj trigger point, 1/2 muscl
20553	Inject trigger points, =/≤ 3
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20610	Drain/inject, joint/bursa
20612	Aspirate/inj ganglion cyst
20615	Treatment of bone cyst
20662	Application of pelvis brace
20663	Application of thigh brace
20973	Bone/skin graft, great toe
20974	Electrical bone stimulation
20979	Us bone stimulation
21030	Excise max/zygoma b9 tumor
21031	Remove exostosis, mandible
21032	Remove exostosis, maxilla
21048	Remove maxilla cyst complex
21076	Prepare face/oral prosthesis
21077	Prepare face/oral prosthesis
21079	Prepare face/oral prosthesis
21080	Prepare face/oral prosthesis
21081	Prepare face/oral prosthesis
21082	Prepare face/oral prosthesis
21083	Prepare face/oral prosthesis
21084	Prepare face/oral prosthesis
21085	Prepare face/oral prosthesis
21086	Prepare face/oral prosthesis
21087	Prepare face/oral prosthesis

ADDENDUM CC.—PROPOSED LIST OF PROCEDURES FOR CY 2008 SUBJECT TO PAYMENT LIMITATION AT THE MPFS NONFACILITY AMOUNT—Continued

HCPCS	Short Description
21088	Prepare face/oral prosthesis
21089	Prepare face/oral prosthesis
21110	Interdental fixation
21440	Treat dental ridge fracture
21920	Biopsy soft tissue of back
23065	Biopsy shoulder tissues
23600	Treat humerus fracture
23620	Treat humerus fracture
24065	Biopsy arm/elbow soft tissue
24200	Removal of arm foreign body
24650	Treat radius fracture
25065	Biopsy forearm soft tissues
25500	Treat fracture of radius
25530	Treat fracture of ulna
25560	Treat fracture radiusamp; ulna
25600	Treat fracture radius/ulna
25622	Treat wrist bone fracture
25630	Treat wrist bone fracture
25650	Treat wrist bone fracture
26010	Drainage of finger abscess
26600	Treat metacarpal fracture
26720	Treat finger fracture, each
26725	Treat finger fracture, each
26740	Treat finger fracture, each
26750	Treat finger fracture, each
27200	Treat tail bone fracture
27613	Biopsy lower leg soft tissue
28001	Drainage of bursa of foot
28010	Incision of toe tendon
28124	Partial removal of toe
28190	Removal of foot foreign body
28220	Release of foot tendon
28230	Incision of foot tendon(s)
28232	Incision of toe tendon
28272	Release of toe joint, each
28430	Treatment of ankle fracture
28450	Treat midfoot fracture, each
28455	Treat midfoot fracture, each
28470	Treat metatarsal fracture
28475	Treat metatarsal fracture
28490	Treat big toe fracture
28495	Treat big toe fracture
28510	Treatment of toe fracture
28515	Treatment of toe fracture
28530	Treat sesamoid bone fracture
28540	Treat foot dislocation
28570	Treat foot dislocation
28600	Treat foot dislocation
29010	Application of body cast
29015	Application of body cast
29025	Application of body cast
29049	Application of figure eight
29055	Application of shoulder cast
29058	Application of shoulder cast
29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29086	Apply finger cast
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29220	Strapping of low back
29240	Strapping of shoulder
29260	Strapping of elbow or wrist

ADDENDUM CC.—PROPOSED LIST OF PROCEDURES FOR CY 2008 SUBJECT TO PAYMENT LIMITATION AT THE MPFS NONFACILITY AMOUNT—Continued

HCPCS	Short Description
29280	Strapping of hand or finger
29345	Application of long leg cast
29355	Application of long leg cast
29358	Apply long leg cast brace
29365	Application of long leg cast
29405	Apply short leg cast
29425	Apply short leg cast
29435	Apply short leg cast
29440	Addition of walker to cast
29445	Apply rigid leg cast
29450	Application of leg cast
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle and/or ft
29550	Strapping of toes
29580	Application of paste boot
29590	Application of foot splint
29700	Removal/revision of cast
29705	Removal/revision of cast
29710	Removal/revision of cast
29715	Removal/revision of cast
29720	Repair of body cast
29730	Windowing of cast
29740	Wedging of cast
29750	Wedging of clubfoot cast
30000	Drainage of nose lesion
30020	Drainage of nose lesion
30100	Intranasal biopsy
30110	Removal of nose polyp(s)
30124	Removal of nose lesion
30200	Injection treatment of nose
30210	Nasal sinus therapy
30300	Remove nasal foreign body
30901	Control of nosebleed
31000	Irrigation, maxillary sinus
31002	Irrigation, sphenoid sinus
31040	Exploration behind upper jaw
31231	Nasal endoscopy, dx
31505	Diagnostic laryngoscopy
31575	Diagnostic laryngoscopy
31579	Diagnostic laryngoscopy
36425	Vein access cutdown > 1 yr
36430	Blood transfusion service
36440	Bl push transfuse, 2 yr or lgt;
36468	Injection(s), spider veins
36470	Injection therapy of vein
36471	Injection therapy of veins
36550	Declot vascular device
36598	Inj w/fluor, eval cv device
37765	Phleb veins - extrem - to 20
37766	Phleb veins - extrem 20+
38220	Bone marrow aspiration
38221	Bone marrow biopsy
38242	Lymphocyte infuse transplant
40490	Biopsy of lip
40702	Repair cleft lip/nasal
40800	Drainage of mouth lesion
40804	Removal, foreign body, mouth
40805	Removal, foreign body, mouth
40806	Incision of lip fold
40808	Biopsy of mouth lesion
40810	Excision of mouth lesion
40812	Excise/repair mouth lesion
40820	Treatment of mouth lesion
41000	Drainage of mouth lesion
41100	Biopsy of tongue
41105	Biopsy of tongue

ADDENDUM CC.—PROPOSED LIST OF PROCEDURES FOR CY 2008 SUBJECT TO PAYMENT LIMITATION AT THE MPFS NONFACILITY AMOUNT—Continued

HCPCS	Short Description
41108	Biopsy of floor of mouth
41110	Excision of tongue lesion
41115	Excision of tongue fold
41805	Removal foreign body, gum
41806	Removal foreign body,jawbone
41820	Excision, gum, each quadrant
41822	Excision of gum lesion
41823	Excision of gum lesion
41825	Excision of gum lesion
41826	Excision of gum lesion
41828	Excision of gum lesion
41830	Removal of gum tissue
41850	Treatment of gum lesion
41872	Repair gum
41874	Repair tooth socket
42100	Biopsy roof of mouth
42104	Excision lesion, mouth roof
42106	Excision lesion, mouth roof
42160	Treatment mouth roof lesion
42280	Preparation, palate mold
42330	Removal of salivary stone
42335	Removal of salivary stone
42400	Biopsy of salivary gland
42650	Dilation of salivary duct
42660	Dilation of salivary duct
42800	Biopsy of throat
42970	Control nose/throat bleeding
45300	Proctosigmoidoscopy dx
45303	Proctosigmoidoscopy dilate
45330	Diagnostic sigmoidoscopy
45520	Treatment of rectal prolapse
46083	Incise external hemorrhoid
46221	Ligation of hemorrhoid(s)
46320	Removal of hemorrhoid clot
46500	Injection into hemorrhoid(s)
46600	Diagnostic anoscopy
46604	Anoscopy and dilation
46606	Anoscopy and biopsy
46614	Anoscopy, control bleeding
46900	Destruction, anal lesion(s)
46910	Destruction, anal lesion(s)
46916	Cryosurgery, anal lesion(s)
46934	Destruction of hemorrhoids
46935	Destruction of hemorrhoids
46936	Destruction of hemorrhoids
46940	Treatment of anal fissure
46942	Treatment of anal fissure
46945	Ligation of hemorrhoids
46946	Ligation of hemorrhoids
50391	Instll rx agnt into rnal tub
50686	Measure ureter pressure
51000	Drainage of bladder
51005	Drainage of bladder
51700	Irrigation of bladder
51701	Insert bladder catheter
51702	Insert temp bladder cath
51703	Insert bladder cath, complex
51705	Change of bladder tube
51720	Treatment of bladder lesion
51725	Simple cystometrogram
51736	Urine flow measurement
51741	Electro-uroflowmetry, first
51784	Anal/urinary muscle study
51792	Urinary reflex study
51795	Urine voiding pressure study
51797	Intraabdominal pressure test
51798	Us urine capacity measure

ADDENDUM CC.—PROPOSED LIST OF PROCEDURES FOR CY 2008 SUBJECT TO PAYMENT LIMITATION AT THE MPFS NONFACILITY AMOUNT—Continued

HCPCS	Short Description
52265	Cystoscopy and treatment
53025	Incision of urethra
53060	Drainage of urethra abscess
53600	Dilate urethra stricture
53601	Dilate urethra stricture
53620	Dilate urethra stricture
53621	Dilate urethra stricture
53660	Dilation of urethra
53661	Dilation of urethra
53850	Prostatic microwave thermotx
53852	Prostatic rf thermotx
53853	Prostatic water thermother
54050	Destruction, penis lesion(s)
54055	Destruction, penis lesion(s)
54056	Cryosurgery, penis lesion(s)
54200	Treatment of penis lesion
54231	Dynamic cavernosometry
54235	Penile injection
54240	Penis study
54250	Penis study
55000	Drainage of hydrocele
55450	Ligation of sperm duct
55600	Incise sperm duct pouch
55870	Electroejaculation
56405	I & D of vulva/perineum
56420	Drainage of gland abscess
56501	Destroy, vulva lesions, sim
56605	Biopsy of vulva/perineum
56606	Biopsy of vulva/perineum
56820	Exam of vulva w/scope
56821	Exam/biopsy of vulva w/scope
57061	Destroy vag lesions, simple
57100	Biopsy of vagina
57150	Treat vagina infection
57160	Insert pessary/other device
57170	Fitting of diaphragm/cap
57420	Exam of vagina w/scope
57421	Exam/biopsy of vag w/scope
57452	Exam of cervix w/scope
57454	Bx/curett of cervix w/scope
57455	Biopsy of cervix w/scope
57456	Endocerv curettage w/scope
57460	Bx of cervix w/scope, leep
57461	Conz of cervix w/scope, leep
57500	Biopsy of cervix
57505	Endocervical curettage
57510	Cauterization of cervix
57511	Cryocautery of cervix
57800	Dilation of cervical canal
58100	Biopsy of uterus lining
58110	Bx done w/colposcopy add-on
58300	Insert intrauterine device
58301	Remove intrauterine device
58321	Artificial insemination
58322	Artificial insemination
58323	Sperm washing
58345	Reopen fallopian tube
58356	Endometrial cryoablation
59000	Amniocentesis, diagnostic
59001	Amniocentesis, therapeutic
59015	Chorion biopsy
59020	Fetal contract stress test
59025	Fetal non-stress test
59100	Remove uterus lesion
59200	Insert cervical dilator
59300	Episiotomy or vaginal repair
60001	Aspirate/inject thyriod cyst

ADDENDUM CC.—PROPOSED LIST OF PROCEDURES FOR CY 2008 SUBJECT TO PAYMENT LIMITATION AT THE MPFS NONFACILITY AMOUNT—Continued

HCPCS	Short Description
60100	Biopsy of thyroid
61000	Remove cranial cavity fluid
61001	Remove cranial cavity fluid
62252	Csf shunt reprogram
62367	Analyze spine infusion pump
62368	Analyze spine infusion pump
63615	Remove lesion of spinal cord
64400	N block inj, trigeminal
64402	N block inj, facial
64405	N block inj, occipital
64408	N block inj, vagus
64412	N block inj, spinal accessor
64413	N block inj, cervical plexus
64418	N block inj, suprascapular
64425	N block inj, ilio-ing/hypogi
64435	N block inj, paracervical
64445	N block inj, sciatic, sng
64450	N block, other peripheral
64505	N block, spenopalatine gangl
64508	N block, carotid sinus s/p
64550	Apply neurostimulator
64555	Implant neuroelectrodes
64565	Implant neuroelectrodes
64612	Destroy nerve, face muscle
64613	Destroy nerve, neck muscle
64614	Destroy nerve, extrem musc
64640	Injection treatment of nerve
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65222	Remove foreign body from eye
65286	Repair of eye wound
65430	Corneal smear
65435	Curette/treat cornea
65600	Revision of cornea

ADDENDUM CC.—PROPOSED LIST OF PROCEDURES FOR CY 2008 SUBJECT TO PAYMENT LIMITATION AT THE MPFS NONFACILITY AMOUNT—Continued

HCPCS	Short Description
65855	Laser surgery of eye
65860	Incise inner eye adhesions
66761	Revision of iris
66762	Revision of iris
66770	Removal of inner eye lesion
67028	Injection eye drug
67101	Repair detached retina
67105	Repair detached retina
67110	Repair detached retina
67145	Treatment of retina
67208	Treatment of retinal lesion
67210	Treatment of retinal lesion
67220	Treatment of choroid lesion
67221	Ocular photodynamic ther
67225	Eye photodynamic ther add-on
67228	Treatment of retinal lesion
67345	Destroy nerve of eye muscle
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67710	Incision of eyelid
67800	Remove eyelid lesion
67801	Remove eyelid lesions
67805	Remove eyelid lesions
67810	Biopsy of eyelid
67820	Revise eyelashes
67825	Revise eyelashes
67840	Remove eyelid lesion
67850	Treat eyelid lesion
67915	Repair eyelid defect
67922	Repair eyelid defect
67930	Repair eyelid wound
67938	Remove eyelid foreign body
68020	Incise/drain eyelid lining
68040	Treatment of eyelid lesions

ADDENDUM CC.—PROPOSED LIST OF PROCEDURES FOR CY 2008 SUBJECT TO PAYMENT LIMITATION AT THE MPFS NONFACILITY AMOUNT—Continued

HCPCS	Short Description
68100	Biopsy of eyelid lining
68110	Remove eyelid lining lesion
68135	Remove eyelid lining lesion
68200	Treat eyelid by injection
68400	Incise/drain tear gland
68420	Incise/drain tear sac
68440	Incise tear duct opening
68530	Clearance of tear duct
68705	Revise tear duct opening
68760	Close tear duct opening
68761	Close tear duct opening
68801	Dilate tear duct opening
68840	Explore/irrigate tear ducts
69000	Drain external ear lesion
69005	Drain external ear lesion
69020	Drain outer ear canal lesion
69100	Biopsy of external ear
69105	Biopsy of external ear canal
69200	Clear outer ear canal
69210	Remove impacted ear wax
69220	Clean out mastoid cavity
69222	Clean out mastoid cavity
69399	Outer ear surgery procedure
69400	Inflate middle ear canal
69401	Inflate middle ear canal
69405	Catheterize middle ear canal
69410	Inset middle ear (baffle)
69420	Incision of eardrum
69424	Remove ventilating tube
69433	Create eardrum opening
69540	Remove ear lesion
69610	Repair of eardrum

ADDENDUM D1.—PROPOSED PAYMENT STATUS INDICATORS

Indicator	Item/code/service	OPPS payment status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services • Clinical Diagnostic Laboratory Services • Non-Implantable Prosthetic and Orthotic Devices • EPO for ESRD Patients • Physical, Occupational, and Speech Therapy • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital • Diagnostic Mammography • Screening Mammography	Not paid under OPPS. Paid by fiscal intermediaries under a fee schedule or payment system other than OPPS.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x).	Not paid under OPPS. • May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x and 13x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPPS or any other Medicare payment system.
E	Items, Codes, and Services: • That are not covered by Medicare based on statutory exclusion • That are not covered by Medicare for reasons other than statutory exclusion • That are not recognized by Medicare but for which an alternate code for the same item or service may be available • For which separate payment is not provided by Medicare.	Not paid under OPPS or any other Medicare payment system.

ADDENDUM D1.—PROPOSED PAYMENT STATUS INDICATORS—Continued

Indicator	Item/code/service	OPPS payment status
F	Corneal Tissue Acquisition; Certain CRNA Services; and Hepatitis B Vaccines.	Not paid under OPPS. Paid at reasonable cost.
G	Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment includes pass-through amount.
H	Pass-Through Device Categories	Separate cost-based pass-through payment; Not subject to co-insurance.
K	(1) Non-Pass-Through Drugs and Biologicals, and Radiopharmaceutical Agents.	(1) Paid under OPPS; Separate APC payment.
	(2) Brachytherapy Sources	(2) Paid under OPPS; Separate APC payment.
	(3) Blood and Blood Products	(3) Paid under OPPS; Separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary	Not paid under OPPS.
N	Items and Services Packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.
Q	Packaged Services Subject to Separate Payment Under OPPS Payment Criteria.	Paid under OPPS; Addendum B displays APC assignments when services are separately payable. (1) Separate APC payment based on OPPS payment criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
S	Significant Procedure, Not Discounted when Multiple	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.
X	Ancillary Services	Paid under OPPS; Separate APC payment.

ADDENDUM D2.—PROPOSED COMMENT INDICATORS

Comment indicator	Descriptor
NF	New code, final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.
NI	New code, interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.
CH	Active HCPCS codes in current year and next calendar year; status indicator and/or APC assignment have changed.

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
00176	Anesth, pharyngeal surgery	C
00192	Anesth, facial bone surgery	C
00214	Anesth, skull drainage	C
00215	Anesth, skull repair/fract	C
00404	Anesth, surgery of breast	C
00406	Anesth, surgery of breast	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 surgry < age 1	C
00562	Anesth, heart surg w/pump	C
00580	Anesth, heart/lung transplnt	C
00604	Anesth, sitting procedure	C
00622	Anesth, removal of nerves	C
00632	Anesth, removal of nerves	C
00670	Anesth, spine, cord surgery	C
00792	Anesth, hemorr/excise liver	C
00794	Anesth, pancreas removal	C
00796	Anesth, for liver transplant	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
00802	Anesth, fat layer removal	C
00844	Anesth, pelvis surgery	C
00846	Anesth, hysterectomy	C
00848	Anesth, pelvic organ surg	C
00864	Anesth, removal of bladder	C
00865	Anesth, removal of prostate	C
00866	Anesth, removal of adrenal	C
00868	Anesth, kidney transplant	C
00882	Anesth, major vein ligation	C
00904	Anesth, perineal surgery	C
00908	Anesth, removal of prostate	C
00932	Anesth, amputation of penis	C
00934	Anesth, penis, nodes removal	C
00936	Anesth, penis, nodes removal	C
00944	Anesth, vaginal hysterectomy	C
01140	Anesth, amputation at pelvis	C
01150	Anesth, pelvic tumor surgery	C
01212	Anesth, hip disarticulation	C
01214	Anesth, hip arthroplasty	C
01232	Anesth, amputation of femur	C
01234	Anesth, radical femur surg	C
01272	Anesth, femoral artery surg	C
01274	Anesth, femoral embolectomy	C
01402	Anesth, knee arthroplasty	C
01404	Anesth, amputation at knee	C
01442	Anesth, knee artery surg	C
01444	Anesth, knee artery repair	C
01486	Anesth, ankle replacement	C
01502	Anesth, lwr leg embolectomy	C
01632	Anesth, surgery of shoulder	C
01634	Anesth, shoulder joint amput	C
01636	Anesth, forequarter amput	C
01638	Anesth, shoulder replacement	C
01652	Anesth, shoulder vessel surg	C
01654	Anesth, shoulder vessel surg	C
01656	Anesth, arm-leg vessel surg	C
01756	Anesth, radical humerus surg	C
01990	Support for organ donor	C
11004	Debride genitalia & perineum	C
11005	Debride abdom wall	C
11006	Debride genit/per/abdom wall	C
11008	Remove mesh from abd wall	C
15756	Free myo/skin flap microvasc	C
15757	Free skin flap, microvasc	C
15758	Free fascial flap, microvasc	C
16036	Escharotomy; add'l incision	C
19200	Removal of breast	C
19220	Removal of breast	C
19271	Revision of chest wall	C
19272	Extensive chest wall surgery	C
19361	Breast reconstruction	C
19364	Breast reconstruction	C
19367	Breast reconstruction	C
19368	Breast reconstruction	C
19369	Breast reconstruction	C
20660	Apply, rem fixation device	C
20661	Application of head brace	C
20664	Halo brace application	C
20802	Replantation, arm, complete	C
20805	Replant forearm, complete	C
20808	Replantation hand, complete	C
20816	Replantation digit, complete	C
20824	Replantation thumb, complete	C
20827	Replantation thumb, complete	C
20838	Replantation foot, complete	C
20930	Spinal bone allograft	C
20931	Spinal bone allograft	C
20936	Spinal bone autograft	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
20937	Spinal bone autograft	C
20938	Spinal bone autograft	C
20955	Fibula bone graft, microvasc	C
20956	Iliac bone graft, microvasc	C
20957	Mt bone graft, microvasc	C
20962	Other bone graft, microvasc	C
20969	Bone/skin graft, microvasc	C
20970	Bone/skin graft, iliac crest	C
21045	Extensive jaw surgery	C
21141	Reconstruct midface, lefort	C
21142	Reconstruct midface, lefort	C
21143	Reconstruct midface, lefort	C
21145	Reconstruct midface, lefort	C
21146	Reconstruct midface, lefort	C
21147	Reconstruct midface, lefort	C
21151	Reconstruct midface, lefort	C
21154	Reconstruct midface, lefort	C
21155	Reconstruct midface, lefort	C
21159	Reconstruct midface, lefort	C
21160	Reconstruct midface, lefort	C
21172	Reconstruct orbit/forehead	C
21179	Reconstruct entire forehead	C
21180	Reconstruct entire forehead	C
21182	Reconstruct cranial bone	C
21183	Reconstruct cranial bone	C
21184	Reconstruct cranial bone	C
21188	Reconstruction of midface	C
21193	Reconst lwr jaw w/o graft	C
21194	Reconst lwr jaw w/graft	C
21196	Reconst lwr jaw w/fixation	C
21247	Reconstruct lower jaw bone	C
21255	Reconstruct lower jaw bone	C
21256	Reconstruction of orbit	C
21268	Revise eye sockets	C
21343	Treatment of sinus fracture	C
21344	Treatment of sinus fracture	C
21346	Treat nose/jaw fracture	C
21347	Treat nose/jaw fracture	C
21348	Treat nose/jaw fracture	C
21360	Treat cheek bone fracture	C
21365	Treat cheek bone fracture	C
21366	Treat cheek bone fracture	C
21385	Treat eye socket fracture	C
21386	Treat eye socket fracture	C
21387	Treat eye socket fracture	C
21395	Treat eye socket fracture	C
21422	Treat mouth roof fracture	C
21423	Treat mouth roof fracture	C
21431	Treat craniofacial fracture	C
21432	Treat craniofacial fracture	C
21433	Treat craniofacial fracture	C
21435	Treat craniofacial fracture	C
21436	Treat craniofacial fracture	C
21510	Drainage of bone lesion	C
21615	Removal of rib	C
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
22112	Remove part, thorax vertebra	C
22114	Remove part, lumbar vertebra	C
22116	Remove extra spine segment	C
22210	Revision of neck spine	C
22212	Revision of thorax spine	C
22214	Revision of lumbar spine	C
22216	Revise, extra spine segment	C
22220	Revision of neck spine	C
22224	Revision of lumbar spine	C
22226	Revise, extra spine segment	C
22318	Treat odontoid fx w/o graft	C
22319	Treat odontoid fx w/graft	C
22325	Treat spine fracture	C
22326	Treat neck spine fracture	C
22327	Treat thorax spine fracture	C
22328	Treat each add spine fx	C
22532	Lat thorax spine fusion	C
22533	Lat lumbar spine fusion	C
22534	Lat thor/lumb, add'l seg	C
22548	Neck spine fusion	C
22554	Neck spine fusion	C
22556	Thorax spine fusion	C
22558	Lumbar spine fusion	C
22585	Additional spinal fusion	C
22590	Spine & skull spinal fusion	C
22595	Neck spinal fusion	C
22600	Neck spine fusion	C
22610	Thorax spine fusion	C
22630	Lumbar spine fusion	C
22632	Spine fusion, extra segment	C
22800	Fusion of spine	C
22802	Fusion of spine	C
22804	Fusion of spine	C
22808	Fusion of spine	C
22810	Fusion of spine	C
22812	Fusion of spine	C
22818	Kyphectomy, 1-2 segments	C
22819	Kyphectomy, 3 or more	C
22830	Exploration of spinal fusion	C
22840	Insert spine fixation device	C
22841	Insert spine fixation device	C
22842	Insert spine fixation device	C
22843	Insert spine fixation device	C
22844	Insert spine fixation device	C
22845	Insert spine fixation device	C
22846	Insert spine fixation device	C
22847	Insert spine fixation device	C
22848	Insert pelv fixation device	C
22849	Reinsert spinal fixation	C
22850	Remove spine fixation device	C
22851	Apply spine prosth device	C
22852	Remove spine fixation device	C
22855	Remove spine fixation device	C
23200	Removal of collar bone	C
23210	Removal of shoulder blade	C
23220	Partial removal of humerus	C
23221	Partial removal of humerus	C
23222	Partial removal of humerus	C
23332	Remove shoulder foreign body	C
23472	Reconstruct shoulder joint	C
23900	Amputation of arm & girdle	C
23920	Amputation at shoulder joint	C
24900	Amputation of upper arm	C
24920	Amputation of upper arm	C
24930	Amputation follow-up surgery	C
24931	Amputate upper arm & implant	C
24940	Revision of upper arm	C
25900	Amputation of forearm	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
25905	Amputation of forearm	C
25909	Amputation follow-up surgery	C
25915	Amputation of forearm	C
25920	Amputate hand at wrist	C
25924	Amputation follow-up surgery	C
25927	Amputation of hand	C
25931	Amputation follow-up surgery	C
26551	Great toe-hand transfer	C
26553	Single transfer, toe-hand	C
26554	Double transfer, toe-hand	C
26556	Toe joint transfer	C
26992	Drainage of bone lesion	C
27005	Incision of hip tendon	C
27006	Incision of hip tendons	C
27025	Incision of hip/thigh fascia	C
27030	Drainage of hip joint	C
27036	Excision of hip joint/muscle	C
27054	Removal of hip joint lining	C
27070	Partial removal of hip bone	C
27071	Partial removal of hip bone	C
27075	Extensive hip surgery	C
27076	Extensive hip surgery	C
27077	Extensive hip surgery	C
27078	Extensive hip surgery	C
27079	Extensive hip surgery	C
27090	Removal of hip prosthesis	C
27091	Removal of hip prosthesis	C
27120	Reconstruction of hip socket	C
27122	Reconstruction of hip socket	C
27125	Partial hip replacement	C
27130	Total hip arthroplasty	C
27132	Total hip arthroplasty	C
27134	Revise hip joint replacement	C
27137	Revise hip joint replacement	C
27138	Revise hip joint replacement	C
27140	Transplant femur ridge	C
27146	Incision of hip bone	C
27147	Revision of hip bone	C
27151	Incision of hip bones	C
27156	Revision of hip bones	C
27158	Revision of pelvis	C
27161	Incision of neck of femur	C
27165	Incision/fixation of femur	C
27170	Repair/graft femur head/neck	C
27175	Treat slipped epiphysis	C
27176	Treat slipped epiphysis	C
27177	Treat slipped epiphysis	C
27178	Treat slipped epiphysis	C
27179	Revise head/neck of femur	C
27181	Treat slipped epiphysis	C
27185	Revision of femur epiphysis	C
27187	Reinforce hip bones	C
27215	Treat pelvic fracture(s)	C
27217	Treat pelvic ring fracture	C
27218	Treat pelvic ring fracture	C
27222	Treat hip socket fracture	C
27226	Treat hip wall fracture	C
27227	Treat hip fracture(s)	C
27228	Treat hip fracture(s)	C
27232	Treat thigh fracture	C
27236	Treat thigh fracture	C
27240	Treat thigh fracture	C
27244	Treat thigh fracture	C
27245	Treat thigh fracture	C
27248	Treat thigh fracture	C
27253	Treat hip dislocation	C
27254	Treat hip dislocation	C
27258	Treat hip dislocation	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
27259	Treat hip dislocation	C
27280	Fusion of sacroiliac joint	C
27282	Fusion of pubic bones	C
27284	Fusion of hip joint	C
27286	Fusion of hip joint	C
27290	Amputation of leg at hip	C
27295	Amputation of leg at hip	C
27303	Drainage of bone lesion	C
27365	Extensive leg surgery	C
27445	Revision of knee joint	C
27447	Total knee arthroplasty	C
27448	Incision of thigh	C
27450	Incision of thigh	C
27454	Realignment of thigh bone	C
27455	Realignment of knee	C
27457	Realignment of knee	C
27465	Shortening of thigh bone	C
27466	Lengthening of thigh bone	C
27468	Shorten/lengthen thighs	C
27470	Repair of thigh	C
27472	Repair/graft of thigh	C
27477	Surgery to stop leg growth	C
27479	Surgery to stop leg growth	C
27485	Surgery to stop leg growth	C
27486	Revise/replace knee joint	C
27487	Revise/replace knee joint	C
27488	Removal of knee prosthesis	C
27495	Reinforce thigh	C
27506	Treatment of thigh fracture	C
27507	Treatment of thigh fracture	C
27511	Treatment of thigh fracture	C
27513	Treatment of thigh fracture	C
27514	Treatment of thigh fracture	C
27519	Treat thigh fx growth plate	C
27535	Treat knee fracture	C
27536	Treat knee fracture	C
27540	Treat knee fracture	C
27556	Treat knee dislocation	C
27557	Treat knee dislocation	C
27558	Treat knee dislocation	C
27580	Fusion of knee	C
27590	Amputate leg at thigh	C
27591	Amputate leg at thigh	C
27592	Amputate leg at thigh	C
27596	Amputation follow-up surgery	C
27598	Amputate lower leg at knee	C
27645	Extensive lower leg surgery	C
27646	Extensive lower leg surgery	C
27702	Reconstruct ankle joint	C
27703	Reconstruction, ankle joint	C
27712	Realignment of lower leg	C
27715	Revision of lower leg	C
27720	Repair of tibia	C
27722	Repair/graft of tibia	C
27724	Repair/graft of tibia	C
27725	Repair of lower leg	C
27727	Repair of lower leg	C
27880	Amputation of lower leg	C
27881	Amputation of lower leg	C
27882	Amputation of lower leg	C
27886	Amputation follow-up surgery	C
27888	Amputation of foot at ankle	C
28800	Amputation of midfoot	C
28805	Amputation thru metatarsal	C
31225	Removal of upper jaw	C
31230	Removal of upper jaw	C
31290	Nasal/sinus endoscopy, surg	C
31291	Nasal/sinus endoscopy, surg	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
31360	Removal of larynx	C
31365	Removal of larynx	C
31367	Partial removal of larynx	C
31368	Partial removal of larynx	C
31370	Partial removal of larynx	C
31375	Partial removal of larynx	C
31380	Partial removal of larynx	C
31382	Partial removal of larynx	C
31390	Removal of larynx & pharynx	C
31395	Reconstruct larynx & pharynx	C
31584	Treat larynx fracture	C
31587	Revision of larynx	C
31725	Clearance of airways	C
31760	Repair of windpipe	C
31766	Reconstruction of windpipe	C
31770	Repair/graft of bronchus	C
31775	Reconstruct bronchus	C
31780	Reconstruct windpipe	C
31781	Reconstruct windpipe	C
31786	Remove windpipe lesion	C
31800	Repair of windpipe injury	C
31805	Repair of windpipe injury	C
32035	Exploration of chest	C
32036	Exploration of chest	C
32095	Biopsy through chest wall	C
32100	Exploration/biopsy of chest	C
32110	Explore/repair chest	C
32120	Re-exploration of chest	C
32124	Explore chest free adhesions	C
32140	Removal of lung lesion(s)	C
32141	Remove/treat lung lesions	C
32150	Removal of lung lesion(s)	C
32151	Remove lung foreign body	C
32160	Open chest heart massage	C
32200	Drain, open, lung lesion	C
32215	Treat chest lining	C
32220	Release of lung	C
32225	Partial release of lung	C
32310	Removal of chest lining	C
32320	Free/remove chest lining	C
32402	Open biopsy chest lining	C
32440	Removal of lung	C
32442	Sleeve pneumonectomy	C
32445	Removal of lung	C
32480	Partial removal of lung	C
32482	Bilobectomy	C
32484	Segmentectomy	C
32486	Sleeve lobectomy	C
32488	Completion pneumonectomy	C
32491	Lung volume reduction	C
32500	Partial removal of lung	C
32501	Repair bronchus add-on	C
32503	Resect apical lung tumor	C
32504	Resect apical lung tum/chest	C
32540	Removal of lung lesion	C
32650	Thoracoscopy, surgical	C
32651	Thoracoscopy, surgical	C
32652	Thoracoscopy, surgical	C
32653	Thoracoscopy, surgical	C
32654	Thoracoscopy, surgical	C
32655	Thoracoscopy, surgical	C
32656	Thoracoscopy, surgical	C
32657	Thoracoscopy, surgical	C
32658	Thoracoscopy, surgical	C
32659	Thoracoscopy, surgical	C
32660	Thoracoscopy, surgical	C
32661	Thoracoscopy, surgical	C
32662	Thoracoscopy, surgical	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
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
33200	Insertion of heart pacemaker	C
33201	Insertion of heart pacemaker	C
33236	Remove electrode/thoracotomy	C
33237	Remove electrode/thoracotomy	C
33238	Remove electrode/thoracotomy	C
33243	Remove eltrd/thoracotomy	C
33245	Insert epic eltrd pace-defib	C
33246	Insert epic eltrd/generator	C
33250	Ablate heart dysrhythm focus	C
33251	Ablate heart dysrhythm focus	C
33253	Reconstruct atria	C
33261	Ablate heart dysrhythm focus	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.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
33426	Repair of mitral valve	C
33427	Repair of mitral valve	C
33430	Replacement of mitral valve	C
33460	Revision of tricuspid valve	C
33463	Valvuloplasty, tricuspid	C
33464	Valvuloplasty, tricuspid	C
33465	Replace tricuspid valve	C
33468	Revision of tricuspid valve	C
33470	Revision of pulmonary valve	C
33471	Valvotomy, pulmonary valve	C
33472	Revision of pulmonary valve	C
33474	Revision of pulmonary valve	C
33475	Replacement, pulmonary valve	C
33476	Revision of heart chamber	C
33478	Revision of heart chamber	C
33496	Repair, prosth valve clot	C
33500	Repair heart vessel fistula	C
33501	Repair heart vessel fistula	C
33502	Coronary artery correction	C
33503	Coronary artery graft	C
33504	Coronary artery graft	C
33505	Repair artery w/tunnel	C
33506	Repair artery, translocation	C
33507	Repair art, intramural	C
33510	CABG, vein, single	C
33511	CABG, vein, two	C
33512	CABG, vein, three	C
33513	CABG, vein, four	C
33514	CABG, vein, five	C
33516	Cabg, vein, six or more	C
33517	CABG, artery-vein, single	C
33518	CABG, artery-vein, two	C
33519	CABG, artery-vein, three	C
33521	CABG, artery-vein, four	C
33522	CABG, artery-vein, five	C
33523	Cabg, art-vein, six or more	C
33530	Coronary artery, bypass/reop	C
33533	CABG, arterial, single	C
33534	CABG, arterial, two	C
33535	CABG, arterial, three	C
33536	Cabg, arterial, four or more	C
33542	Removal of heart lesion	C
33545	Repair of heart damage	C
33548	Restore/remodel, ventricle	C
33572	Open coronary endarterectomy	C
33600	Closure of valve	C
33602	Closure of valve	C
33606	Anastomosis/artery-aorta	C
33608	Repair anomaly w/conduit	C
33610	Repair by enlargement	C
33611	Repair double ventricle	C
33612	Repair double ventricle	C
33615	Repair, modified fontan	C
33617	Repair single ventricle	C
33619	Repair single ventricle	C
33641	Repair heart septum defect	C
33645	Revision of heart veins	C
33647	Repair heart septum defects	C
33660	Repair of heart defects	C
33665	Repair of heart defects	C
33670	Repair of heart chambers	C
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
33702	Repair of heart defects	C
33710	Repair of heart defects	C
33720	Repair of heart defect	C
33722	Repair of heart defect	C
33730	Repair heart-vein defect(s)	C
33732	Repair heart-vein defect	C
33735	Revision of heart chamber	C
33736	Revision of heart chamber	C
33737	Revision of heart chamber	C
33750	Major vessel shunt	C
33755	Major vessel shunt	C
33762	Major vessel shunt	C
33764	Major vessel shunt & graft	C
33766	Major vessel shunt	C
33767	Major vessel shunt	C
33768	Cavopulmonary shunting	C
33770	Repair great vessels defect	C
33771	Repair great vessels defect	C
33774	Repair great vessels defect	C
33775	Repair great vessels defect	C
33776	Repair great vessels defect	C
33777	Repair great vessels defect	C
33778	Repair great vessels defect	C
33779	Repair great vessels defect	C
33780	Repair great vessels defect	C
33781	Repair great vessels defect	C
33786	Repair arterial trunk	C
33788	Revision of pulmonary artery	C
33800	Aortic suspension	C
33802	Repair vessel defect	C
33803	Repair vessel defect	C
33813	Repair septal defect	C
33814	Repair septal defect	C
33820	Revise major vessel	C
33822	Revise major vessel	C
33824	Revise major vessel	C
33840	Remove aorta constriction	C
33845	Remove aorta constriction	C
33851	Remove aorta constriction	C
33852	Repair septal defect	C
33853	Repair septal defect	C
33860	Ascending aortic graft	C
33861	Ascending aortic graft	C
33863	Ascending aortic graft	C
33870	Transverse aortic arch graft	C
33875	Thoracic aortic graft	C
33877	Thoracoabdominal graft	C
33880	Endovasc taa repr incl subcl	C
33881	Endovasc taa repr w/o subcl	C
33883	Insert endovasc prosth, taa	C
33884	Endovasc prosth, taa, add-on	C
33886	Endovasc prosth, delayed	C
33889	Artery transpose/endovas taa	C
33891	Car-car bp grft/endovas taa	C
33910	Remove lung artery emboli	C
33915	Remove lung artery emboli	C
33916	Surgery of great vessel	C
33917	Repair pulmonary artery	C
33920	Repair pulmonary atresia	C
33922	Transect pulmonary artery	C
33924	Remove pulmonary shunt	C
33925	Rpr pul art unifocal w/o cpb	C
33926	Repr pul art, unifocal w/cpb	C
33930	Removal of donor heart/lung	C
33933	Prepare donor heart/lung	C
33935	Transplantation, heart/lung	C
33940	Removal of donor heart	C
33944	Prepare donor heart	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
33945	Transplantation of heart	C
33960	External circulation assist	C
33961	External circulation assist	C
33967	Insert ia percut device	C
33968	Remove aortic assist device	C
33970	Aortic circulation assist	C
33971	Aortic circulation assist	C
33973	Insert balloon device	C
33974	Remove intra-aortic balloon	C
33975	Implant ventricular device	C
33976	Implant ventricular device	C
33977	Remove ventricular device	C
33978	Remove ventricular device	C
33979	Insert intracorporeal device	C
33980	Remove intracorporeal device	C
34001	Removal of artery clot	C
34051	Removal of artery clot	C
34151	Removal of artery clot	C
34401	Removal of vein clot	C
34451	Removal of vein clot	C
34502	Reconstruct vena cava	C
34800	Endovas aaa repr w/sm tube	C
34802	Endovas aaa repr w/2-p part	C
34803	Endovas aaa repr w/3-p part	C
34804	Endovas aaa repr w/1-p part	C
34805	Endovas aaa repr w/long tube	C
34808	Endovas iliac a device addon	C
34812	Xpose for endoprosth, femorl	C
34813	Femoral endovas graft add-on	C
34820	Xpose for endoprosth, iliac	C
34825	Endovasc extend prosth, init	C
34826	Endovasc exten prosth, add'l	C
34830	Open aortic tube prosth repr	C
34831	Open aortoiliac prosth repr	C
34832	Open aortofemor prosth repr	C
34833	Xpose for endoprosth, iliac	C
34834	Xpose, endoprosth, brachial	C
34900	Endovasc iliac repr w/graft	C
35001	Repair defect of artery	C
35002	Repair artery rupture, neck	C
35005	Repair defect of artery	C
35013	Repair artery rupture, arm	C
35021	Repair defect of artery	C
35022	Repair artery rupture, chest	C
35045	Repair defect of arm artery	C
35081	Repair defect of artery	C
35082	Repair artery rupture, aorta	C
35091	Repair defect of artery	C
35092	Repair artery rupture, aorta	C
35102	Repair defect of artery	C
35103	Repair artery rupture, groin	C
35111	Repair defect of artery	C
35112	Repair artery rupture,spleen	C
35121	Repair defect of artery	C
35122	Repair artery rupture, belly	C
35131	Repair defect of artery	C
35132	Repair artery rupture, groin	C
35141	Repair defect of artery	C
35142	Repair artery rupture, thigh	C
35151	Repair defect of artery	C
35152	Repair artery rupture, knee	C
35182	Repair blood vessel lesion	C
35189	Repair blood vessel lesion	C
35211	Repair blood vessel lesion	C
35216	Repair blood vessel lesion	C
35221	Repair blood vessel lesion	C
35241	Repair blood vessel lesion	C
35246	Repair blood vessel lesion	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
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
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
35381	Rechanneling of artery	C
35390	Reoperation, carotid add-on	C
35400	Angioscopy	C
35450	Repair arterial blockage	C
35452	Repair arterial blockage	C
35454	Repair arterial blockage	C
35456	Repair arterial blockage	C
35480	Atherectomy, open	C
35481	Atherectomy, open	C
35482	Atherectomy, open	C
35483	Atherectomy, open	C
35501	Artery bypass graft	C
35506	Artery bypass graft	C
35507	Artery bypass graft	C
35508	Artery bypass graft	C
35509	Artery bypass graft	C
35510	Artery bypass graft	C
35511	Artery bypass graft	C
35512	Artery bypass graft	C
35515	Artery bypass graft	C
35516	Artery bypass graft	C
35518	Artery bypass graft	C
35521	Artery bypass graft	C
35522	Artery bypass graft	C
35525	Artery bypass graft	C
35526	Artery bypass graft	C
35531	Artery bypass graft	C
35533	Artery bypass graft	C
35536	Artery bypass graft	C
35541	Artery bypass graft	C
35546	Artery bypass graft	C
35548	Artery bypass graft	C
35549	Artery bypass graft	C
35551	Artery bypass graft	C
35556	Artery bypass graft	C
35558	Artery bypass graft	C
35560	Artery bypass graft	C
35563	Artery bypass graft	C
35565	Artery bypass graft	C
35566	Artery bypass graft	C
35571	Artery bypass graft	C
35583	Vein bypass graft	C
35585	Vein bypass graft	C
35587	Vein bypass graft	C
35600	Harvest artery for cabg	C
35601	Artery bypass graft	C
35606	Artery bypass graft	C
35612	Artery bypass graft	C
35616	Artery bypass graft	C
35621	Artery bypass graft	C
35623	Bypass graft, not vein	C
35626	Artery bypass graft	C
35631	Artery bypass graft	C
35636	Artery bypass graft	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
35641	Artery bypass graft	C
35642	Artery bypass graft	C
35645	Artery bypass graft	C
35646	Artery bypass graft	C
35647	Artery bypass graft	C
35650	Artery bypass graft	C
35651	Artery bypass graft	C
35654	Artery bypass graft	C
35656	Artery bypass graft	C
35661	Artery bypass graft	C
35663	Artery bypass graft	C
35665	Artery bypass graft	C
35666	Artery bypass graft	C
35671	Artery bypass graft	C
35681	Composite bypass graft	C
35682	Composite bypass graft	C
35683	Composite bypass graft	C
35691	Arterial transposition	C
35693	Arterial transposition	C
35694	Arterial transposition	C
35695	Arterial transposition	C
35697	Reimplant artery each	C
35700	Reoperation, bypass graft	C
35701	Exploration, carotid artery	C
35721	Exploration, femoral artery	C
35741	Exploration popliteal artery	C
35800	Explore neck vessels	C
35820	Explore chest vessels	C
35840	Explore abdominal vessels	C
35870	Repair vessel graft defect	C
35901	Excision, graft, neck	C
35905	Excision, graft, thorax	C
35907	Excision, graft, abdomen	C
36660	Insertion catheter, artery	C
36822	Insertion of cannula(s)	C
36823	Insertion of cannula(s)	C
37140	Revision of circulation	C
37145	Revision of circulation	C
37160	Revision of circulation	C
37180	Revision of circulation	C
37181	Splice spleen/kidney veins	C
37182	Insert hepatic shunt (tips)	C
37215	Transcath stent, cca w/eps	C
37216	Transcath stent, cca w/o 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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
39499	Chest procedure	C
39501	Repair diaphragm laceration	C
39502	Repair paraesophageal hernia	C
39503	Repair of diaphragm hernia	C
39520	Repair of diaphragm hernia	C
39530	Repair of diaphragm hernia	C
39531	Repair of diaphragm hernia	C
39540	Repair of diaphragm hernia	C
39541	Repair of diaphragm hernia	C
39545	Revision of diaphragm	C
39560	Resect diaphragm, simple	C
39561	Resect diaphragm, complex	C
39599	Diaphragm surgery procedure	C
41130	Partial removal of tongue	C
41135	Tongue and neck surgery	C
41140	Removal of tongue	C
41145	Tongue removal, neck surgery	C
41150	Tongue, mouth, jaw surgery	C
41153	Tongue, mouth, neck surgery	C
41155	Tongue, jaw, & neck surgery	C
42426	Excise parotid gland/lesion	C
42845	Extensive surgery of throat	C
42894	Revision of pharyngeal walls	C
42953	Repair throat, esophagus	C
42961	Control throat bleeding	C
42971	Control nose/throat bleeding	C
43045	Incision of esophagus	C
43100	Excision of esophagus lesion	C
43101	Excision of esophagus lesion	C
43107	Removal of esophagus	C
43108	Removal of esophagus	C
43112	Removal of esophagus	C
43113	Removal of esophagus	C
43116	Partial removal of esophagus	C
43117	Partial removal of esophagus	C
43118	Partial removal of esophagus	C
43121	Partial removal of esophagus	C
43122	Partial removal of esophagus	C
43123	Partial removal of esophagus	C
43124	Removal of esophagus	C
43135	Removal of esophagus pouch	C
43300	Repair of esophagus	C
43305	Repair esophagus and fistula	C
43310	Repair of esophagus	C
43312	Repair esophagus and fistula	C
43313	Esophagoplasty congenital	C
43314	Tracheo-esophagoplasty cong	C
43320	Fuse esophagus & stomach	C
43324	Revise esophagus & stomach	C
43325	Revise esophagus & stomach	C
43326	Revise esophagus & stomach	C
43330	Repair of esophagus	C
43331	Repair of esophagus	C
43340	Fuse esophagus & intestine	C
43341	Fuse esophagus & intestine	C
43350	Surgical opening, esophagus	C
43351	Surgical opening, esophagus	C
43352	Surgical opening, esophagus	C
43360	Gastrointestinal repair	C
43361	Gastrointestinal repair	C
43400	Ligate esophagus veins	C
43401	Esophagus surgery for veins	C
43405	Ligate/staple esophagus	C
43410	Repair esophagus wound	C
43415	Repair esophagus wound	C
43420	Repair esophagus opening	C
43425	Repair esophagus opening	C
43460	Pressure treatment esophagus	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
43496	Free jejunum flap, microvasc	C
43500	Surgical opening of stomach	C
43501	Surgical repair of stomach	C
43502	Surgical repair of stomach	C
43520	Incision of pyloric muscle	C
43605	Biopsy of stomach	C
43610	Excision of stomach lesion	C
43611	Excision of stomach lesion	C
43620	Removal of stomach	C
43621	Removal of stomach	C
43622	Removal of stomach	C
43631	Removal of stomach, partial	C
43632	Removal of stomach, partial	C
43633	Removal of stomach, partial	C
43634	Removal of stomach, partial	C
43635	Removal of stomach, partial	C
43640	Vagotomy & pylorus repair	C
43641	Vagotomy & pylorus repair	C
43644	Lap gastric bypass/roux-en-y	C
43645	Lap gastr bypass incl smll i	C
43770	Lap, place gastr adjust band	C
43771	Lap, revise adjust gast band	C
43772	Lap, remove adjust gast band	C
43773	Lap, change adjust gast band	C
43774	Lap remov adj gast band/port	C
43800	Reconstruction of pylorus	C
43810	Fusion of stomach and bowel	C
43820	Fusion of stomach and bowel	C
43825	Fusion of stomach and bowel	C
43832	Place gastrostomy tube	C
43840	Repair of stomach lesion	C
43842	V-band gastroplasty	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
44005	Freeing of bowel adhesion	C
44010	Incision of small bowel	C
44015	Insert needle cath bowel	C
44020	Explore small intestine	C
44021	Decompress small bowel	C
44025	Incision of large bowel	C
44050	Reduce bowel obstruction	C
44055	Correct malrotation of bowel	C
44110	Excise intestine lesion(s)	C
44111	Excision of bowel lesion(s)	C
44120	Removal of small intestine	C
44121	Removal of small intestine	C
44125	Removal of small intestine	C
44126	Enterectomy w/o taper, cong	C
44127	Enterectomy w/taper, cong	C
44128	Enterectomy cong, add-on	C
44130	Bowel to bowel fusion	C
44132	Enterectomy, cadaver donor	C
44133	Enterectomy, live donor	C
44135	Intestine transplnt, cadaver	C
44136	Intestine transplant, live	C
44137	Remove intestinal allograft	C
44139	Mobilization of colon	C
44140	Partial removal of colon	C
44141	Partial removal of colon	C
44143	Partial removal of colon	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
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
44152	Removal of colon/ileostomy	C
44153	Removal of colon/ileostomy	C
44155	Removal of colon/ileostomy	C
44156	Removal of colon/ileostomy	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	Laparo total proctocolectomy	C
44212	Laparo total proctocolectomy	C
44227	Lap, close enterostomy	C
44300	Open bowel to skin	C
44310	Ileostomy/jejunostomy	C
44314	Revision of ileostomy	C
44316	Devise bowel pouch	C
44320	Colostomy	C
44322	Colostomy with biopsies	C
44345	Revision of colostomy	C
44346	Revision of colostomy	C
44602	Suture, small intestine	C
44603	Suture, small intestine	C
44604	Suture, large intestine	C
44605	Repair of bowel lesion	C
44615	Intestinal stricturoplasty	C
44620	Repair bowel opening	C
44625	Repair bowel opening	C
44626	Repair bowel opening	C
44640	Repair bowel-skin fistula	C
44650	Repair bowel fistula	C
44660	Repair bowel-bladder fistula	C
44661	Repair bowel-bladder fistula	C
44680	Surgical revision, intestine	C
44700	Suspend bowel w/prosthesis	C
44715	Prepare donor intestine	C
44720	Prep donor intestine/venous	C
44721	Prep donor intestine/artery	C
44800	Excision of bowel pouch	C
44820	Excision of mesentery lesion	C
44850	Repair of mesentery	C
44899	Bowel surgery procedure	C
44900	Drain app abscess, open	C
44950	Appendectomy	C
44955	Appendectomy add-on	C
44960	Appendectomy	C
45110	Removal of rectum	C
45111	Partial removal of rectum	C
45112	Removal of rectum	C
45113	Partial proctectomy	C
45114	Partial removal of rectum	C
45116	Partial removal of rectum	C
45119	Remove rectum w/reservoir	C
45120	Removal of rectum	C
45121	Removal of rectum and colon	C
45123	Partial proctectomy	C
45126	Pelvic exenteration	C
45130	Excision of rectal prolapse	C
45135	Excision of rectal prolapse	C
45136	Excise ileoanal reservior	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
45395	Lap, removal of rectum	C
45397	Lap, remove rectum w/pouch	C
45400	Laparoscopic proctopexy	C
45402	Lap proctopexy w/sig resect	C
45540	Correct rectal prolapse	C
45550	Repair rectum/remove sigmoid	C
45562	Exploration/repair of rectum	C
45563	Exploration/repair of rectum	C
45800	Repair rect/bladder fistula	C
45805	Repair fistula w/colostomy	C
45820	Repair rectourethral fistula	C
45825	Repair fistula w/colostomy	C
46705	Repair of anal stricture	C
46710	Repr per/vag pouch sngl proc	C
46712	Repr per/vag pouch dbl proc	C
46715	Rep perf anoper fistu	C
46716	Rep perf anoper/vestib fistu	C
46730	Construction of absent anus	C
46735	Construction of absent anus	C
46740	Construction of absent anus	C
46742	Repair of imperforated anus	C
46744	Repair of cloacal anomaly	C
46746	Repair of cloacal anomaly	C
46748	Repair of cloacal anomaly	C
46751	Repair of anal sphincter	C
47010	Open drainage, liver lesion	C
47015	Inject/aspirate liver cyst	C
47100	Wedge biopsy of liver	C
47120	Partial removal of liver	C
47122	Extensive removal of liver	C
47125	Partial removal of liver	C
47130	Partial removal of liver	C
47133	Removal of donor liver	C
47135	Transplantation of liver	C
47136	Transplantation of liver	C
47140	Partial removal, donor liver	C
47141	Partial removal, donor liver	C
47142	Partial removal, donor liver	C
47143	Prep donor liver, whole	C
47144	Prep donor liver, 3-segment	C
47145	Prep donor liver, lobe split	C
47146	Prep donor liver/venous	C
47147	Prep donor liver/arterial	C
47300	Surgery for liver lesion	C
47350	Repair liver wound	C
47360	Repair liver wound	C
47361	Repair liver wound	C
47362	Repair liver wound	C
47380	Open ablate liver tumor rf	C
47381	Open ablate liver tumor cryo	C
47400	Incision of liver duct	C
47420	Incision of bile duct	C
47425	Incision of bile duct	C
47460	Incise bile duct sphincter	C
47480	Incision of gallbladder	C
47550	Bile duct endoscopy add-on	C
47570	Laparo cholecystoenterostomy	C
47600	Removal of gallbladder	C
47605	Removal of gallbladder	C
47610	Removal of gallbladder	C
47612	Removal of gallbladder	C
47620	Removal of gallbladder	C
47700	Exploration of bile ducts	C
47701	Bile duct revision	C
47711	Excision of bile duct tumor	C
47712	Excision of bile duct tumor	C
47715	Excision of bile duct cyst	C
47716	Fusion of bile duct cyst	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
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
48005	Resect/debride pancreas	C
48020	Removal of pancreatic stone	C
48100	Biopsy of pancreas, open	C
48120	Removal of pancreas lesion	C
48140	Partial removal of pancreas	C
48145	Partial removal of pancreas	C
48146	Pancreatectomy	C
48148	Removal of pancreatic duct	C
48150	Partial removal of pancreas	C
48152	Pancreatectomy	C
48153	Pancreatectomy	C
48154	Pancreatectomy	C
48155	Removal of pancreas	C
48180	Fuse pancreas and bowel	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
48551	Prep donor pancreas	C
48552	Prep donor pancreas/venous	C
48554	Transpl allograft pancreas	C
48556	Removal, allograft pancreas	C
49000	Exploration of abdomen	C
49002	Reopening of abdomen	C
49010	Exploration behind abdomen	C
49020	Drain abdominal abscess	C
49040	Drain, open, abdom abscess	C
49060	Drain, open, retrop abscess	C
49062	Drain to peritoneal cavity	C
49201	Remove abdom lesion, complex	C
49215	Excise sacral spine tumor	C
49220	Multiple surgery, abdomen	C
49255	Removal of omentum	C
49425	Insert abdomen-venous drain	C
49428	Ligation of shunt	C
49605	Repair umbilical lesion	C
49606	Repair umbilical lesion	C
49610	Repair umbilical lesion	C
49611	Repair umbilical lesion	C
49900	Repair of abdominal wall	C
49904	Omental flap, extra-abdom	C
49905	Omental flap, intra-abdom	C
49906	Free omental flap, microvasc	C
50010	Exploration of kidney	C
50040	Drainage of kidney	C
50045	Exploration of kidney	C
50060	Removal of kidney stone	C
50065	Incision of kidney	C
50070	Incision of kidney	C
50075	Removal of kidney stone	C
50100	Revise kidney blood vessels	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
50120	Exploration of kidney	C
50125	Explore and drain kidney	C
50130	Removal of kidney stone	C
50135	Exploration of kidney	C
50205	Biopsy of kidney	C
50220	Remove kidney, open	C
50225	Removal kidney open, complex	C
50230	Removal kidney open, radical	C
50234	Removal of kidney & ureter	C
50236	Removal of kidney & ureter	C
50240	Partial removal of kidney	C
50250	Cryoablate renal mass open	C
50280	Removal of kidney lesion	C
50290	Removal of kidney lesion	C
50300	Remove cadaver donor kidney	C
50320	Remove kidney, living donor	C
50323	Prep cadaver renal allograft	C
50325	Prep donor renal graft	C
50327	Prep renal graft/venous	C
50328	Prep renal graft/arterial	C
50329	Prep renal graft/ureteral	C
50340	Removal of kidney	C
50360	Transplantation of kidney	C
50365	Transplantation of kidney	C
50370	Remove transplanted kidney	C
50380	Reimplantation of kidney	C
50400	Revision of kidney/ureter	C
50405	Revision of kidney/ureter	C
50500	Repair of kidney wound	C
50520	Close kidney-skin fistula	C
50525	Repair renal-abdomen fistula	C
50526	Repair renal-abdomen fistula	C
50540	Revision of horseshoe kidney	C
50545	Laparo radical nephrectomy	C
50546	Laparoscopic nephrectomy	C
50547	Laparo removal donor kidney	C
50548	Laparo remove w/ureter	C
50580	Kidney endoscopy & treatment	C
50600	Exploration of ureter	C
50605	Insert ureteral support	C
50610	Removal of ureter stone	C
50620	Removal of ureter stone	C
50630	Removal of ureter stone	C
50650	Removal of ureter	C
50660	Removal of ureter	C
50700	Revision of ureter	C
50715	Release of ureter	C
50722	Release of ureter	C
50725	Release/revise ureter	C
50727	Revise ureter	C
50728	Revise ureter	C
50740	Fusion of ureter & kidney	C
50750	Fusion of ureter & kidney	C
50760	Fusion of ureters	C
50770	Splicing of ureters	C
50780	Reimplant ureter in bladder	C
50782	Reimplant ureter in bladder	C
50783	Reimplant ureter in bladder	C
50785	Reimplant ureter in bladder	C
50800	Implant ureter in bowel	C
50810	Fusion of ureter & bowel	C
50815	Urine shunt to intestine	C
50820	Construct bowel bladder	C
50825	Construct bowel bladder	C
50830	Revise urine flow	C
50840	Replace ureter by bowel	C
50845	Appendico-vesicostomy	C
50860	Transplant ureter to skin	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
50900	Repair of ureter	C
50920	Closure ureter/skin fistula	C
50930	Closure ureter/bowel fistula	C
50940	Release of ureter	C
51060	Removal of ureter stone	C
51525	Removal of bladder lesion	C
51530	Removal of bladder lesion	C
51535	Repair of ureter lesion	C
51550	Partial removal of bladder	C
51555	Partial removal of bladder	C
51565	Revise bladder & ureter(s)	C
51570	Removal of bladder	C
51575	Removal of bladder & nodes	C
51580	Remove bladder/revise tract	C
51585	Removal of bladder & nodes	C
51590	Remove bladder/revise tract	C
51595	Remove bladder/revise tract	C
51596	Remove bladder/create pouch	C
51597	Removal of pelvic structures	C
51800	Revision of bladder/urethra	C
51820	Revision of urinary tract	C
51840	Attach bladder/urethra	C
51841	Attach bladder/urethra	C
51845	Repair bladder neck	C
51860	Repair of bladder wound	C
51865	Repair of bladder wound	C
51900	Repair bladder/vagina lesion	C
51920	Close bladder-uterus fistula	C
51925	Hysterectomy/bladder repair	C
51940	Correction of bladder defect	C
51960	Revision of bladder & bowel	C
51980	Construct bladder opening	C
53415	Reconstruction of urethra	C
53448	Remov/replc ur sphinctr comp	C
54125	Removal of penis	C
54130	Remove penis & nodes	C
54135	Remove penis & nodes	C
54332	Revise penis/urethra	C
54336	Revise penis/urethra	C
54390	Repair penis and bladder	C
54411	Remov/replc penis pros, comp	C
54417	Remv/replc penis pros, compl	C
54430	Revision of penis	C
54535	Extensive testis surgery	C
54650	Orchiopexy (Fowler-Stephens)	C
55605	Incise sperm duct pouch	C
55650	Remove sperm duct pouch	C
55801	Removal of prostate	C
55810	Extensive prostate surgery	C
55812	Extensive prostate surgery	C
55815	Extensive prostate surgery	C
55821	Removal of prostate	C
55831	Removal of prostate	C
55840	Extensive prostate surgery	C
55842	Extensive prostate surgery	C
55845	Extensive prostate surgery	C
55862	Extensive prostate surgery	C
55865	Extensive prostate surgery	C
55866	Laparo radical prostatectomy	C
56630	Extensive vulva surgery	C
56631	Extensive vulva surgery	C
56632	Extensive vulva surgery	C
56633	Extensive vulva surgery	C
56634	Extensive vulva surgery	C
56637	Extensive vulva surgery	C
56640	Extensive vulva surgery	C
57110	Remove vagina wall, complete	C
57111	Remove vagina tissue, compl	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
57112	Vaginectomy w/nodes, compl	C
57270	Repair of bowel pouch	C
57280	Suspension of vagina	C
57282	Colpopexy, extraperitoneal	C
57283	Colpopexy, intraperitoneal	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
58260	Vaginal hysterectomy	C
58262	Vag hyst including t/o	C
58263	Vag hyst w/t/o & vag repair	C
58267	Vag hyst w/urinary repair	C
58270	Vag hyst w/enterocele repair	C
58275	Hysterectomy/revise vagina	C
58280	Hysterectomy/revise vagina	C
58285	Extensive hysterectomy	C
58290	Vag hyst complex	C
58291	Vag hyst incl t/o, complex	C
58292	Vag hyst t/o & repair, compl	C
58293	Vag hyst w/uro repair, compl	C
58294	Vag hyst w/enterocele, compl	C
58400	Suspension of uterus	C
58410	Suspension of uterus	C
58520	Repair of ruptured uterus	C
58540	Revision of uterus	C
58605	Division of fallopian tube	C
58611	Ligate oviduct(s) add-on	C
58700	Removal of fallopian tube	C
58720	Removal of ovary/tube(s)	C
58740	Revise fallopian tube(s)	C
58750	Repair oviduct	C
58752	Revise ovarian tube(s)	C
58760	Remove tubal obstruction	C
58805	Drainage of ovarian cyst(s)	C
58822	Drain ovary abscess, percut	C
58825	Transposition, ovary(s)	C
58940	Removal of ovary(s)	C
58943	Removal of ovary(s)	C
58950	Resect ovarian malignancy	C
58951	Resect ovarian malignancy	C
58952	Resect ovarian malignancy	C
58953	Tah, rad dissect for debulk	C
58954	Tah rad debulk/lymph remove	C
58956	Bso, omentectomy w/tah	C
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
59830	Treat uterus infection	C
59850	Abortion	C
59851	Abortion	C
59852	Abortion	C
59855	Abortion	C
59856	Abortion	C
59857	Abortion	C
60254	Extensive thyroid surgery	C
60270	Removal of thyroid	C
60271	Removal of thyroid	C
60502	Re-explore parathyroids	C
60505	Explore parathyroid glands	C
60520	Removal of thymus gland	C
60521	Removal of thymus gland	C
60522	Removal of thymus gland	C
60540	Explore adrenal gland	C
60545	Explore adrenal gland	C
60600	Remove carotid body lesion	C
60605	Remove carotid body lesion	C
60650	Laparoscopy adrenalectomy	C
61105	Twist drill hole	C
61107	Drill skull for implantation	C
61108	Drill skull for drainage	C
61120	Burr hole for puncture	C
61140	Pierce skull for biopsy	C
61150	Pierce skull for drainage	C
61151	Pierce skull for drainage	C
61154	Pierce skull & remove clot	C
61156	Pierce skull for drainage	C
61210	Pierce skull, implant device	C
61250	Pierce skull & explore	C
61253	Pierce skull & explore	C
61304	Open skull for exploration	C
61305	Open skull for exploration	C
61312	Open skull for drainage	C
61313	Open skull for drainage	C
61314	Open skull for drainage	C
61315	Open skull for drainage	C
61316	Implt cran bone flap to abdo	C
61320	Open skull for drainage	C
61321	Open skull for drainage	C
61322	Decompressive craniotomy	C
61323	Decompressive lobectomy	C
61332	Explore/biopsy eye socket	C
61333	Explore orbit/remove lesion	C
61340	Subtemporal decompression	C
61343	Incise skull (press relief)	C
61345	Relieve cranial pressure	C
61440	Incise skull for surgery	C
61450	Incise skull for surgery	C
61458	Incise skull for brain wound	C
61460	Incise skull for surgery	C
61470	Incise skull for surgery	C
61480	Incise skull for surgery	C
61490	Incise skull for surgery	C
61500	Removal of skull lesion	C
61501	Remove infected skull bone	C
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
61526	Removal of brain lesion	C
61530	Removal of brain lesion	C
61531	Implant brain electrodes	C
61533	Implant brain electrodes	C
61534	Removal of brain lesion	C
61535	Remove brain electrodes	C
61536	Removal of brain lesion	C
61537	Removal of brain tissue	C
61538	Removal of brain tissue	C
61539	Removal of brain tissue	C
61540	Removal of brain tissue	C
61541	Incision of brain tissue	C
61542	Removal of brain tissue	C
61543	Removal of brain tissue	C
61544	Remove & treat brain lesion	C
61545	Excision of brain tumor	C
61546	Removal of pituitary gland	C
61548	Removal of pituitary gland	C
61550	Release of skull seams	C
61552	Release of skull seams	C
61556	Incise skull/sutures	C
61557	Incise skull/sutures	C
61558	Excision of skull/sutures	C
61559	Excision of skull/sutures	C
61563	Excision of skull tumor	C
61564	Excision of skull tumor	C
61566	Removal of brain tissue	C
61567	Incision of brain tissue	C
61570	Remove foreign body, brain	C
61571	Incise skull for brain wound	C
61575	Skull base/brainstem surgery	C
61576	Skull base/brainstem surgery	C
61580	Craniofacial approach, skull	C
61581	Craniofacial approach, skull	C
61582	Craniofacial approach, skull	C
61583	Craniofacial approach, skull	C
61584	Orbitocranial approach/skull	C
61585	Orbitocranial approach/skull	C
61586	Resect nasopharynx, skull	C
61590	Infratemporal approach/skull	C
61591	Infratemporal approach/skull	C
61592	Orbitocranial approach/skull	C
61595	Transtemporal approach/skull	C
61596	Transcochlear approach/skull	C
61597	Transcondylar approach/skull	C
61598	Transpetrosal approach/skull	C
61600	Resect/excise cranial lesion	C
61601	Resect/excise cranial lesion	C
61605	Resect/excise cranial lesion	C
61606	Resect/excise cranial lesion	C
61607	Resect/excise cranial lesion	C
61608	Resect/excise cranial lesion	C
61609	Transect artery, sinus	C
61610	Transect artery, sinus	C
61611	Transect artery, sinus	C
61612	Transect artery, sinus	C
61613	Remove aneurysm, sinus	C
61615	Resect/excise lesion, skull	C
61616	Resect/excise lesion, skull	C
61618	Repair dura	C
61619	Repair dura	C
61624	Transcath occlusion, cns	C
61680	Intracranial vessel surgery	C
61682	Intracranial vessel surgery	C
61684	Intracranial vessel surgery	C
61686	Intracranial vessel surgery	C
61690	Intracranial vessel surgery	C
61692	Intracranial vessel surgery	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
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
61770	Incise skull for treatment	C
61850	Implant neuroelectrodes	C
61860	Implant neuroelectrodes	C
61863	Implant neuroelectrode	C
61864	Implant neuroelectrde, addl	C
61867	Implant neuroelectrode	C
61868	Implant neuroelectrde, add'l	C
61870	Implant neuroelectrodes	C
61875	Implant neuroelectrodes	C
62005	Treat skull fracture	C
62010	Treatment of head injury	C
62100	Repair brain fluid leakage	C
62115	Reduction of skull defect	C
62116	Reduction of skull defect	C
62117	Reduction of skull defect	C
62120	Repair skull cavity lesion	C
62121	Incise skull repair	C
62140	Repair of skull defect	C
62141	Repair of skull defect	C
62142	Remove skull plate/flap	C
62143	Replace skull plate/flap	C
62145	Repair of skull & brain	C
62146	Repair of skull with graft	C
62147	Repair of skull with graft	C
62148	Retr bone flap to fix skull	C
62161	Dissect brain w/scope	C
62162	Remove colloid cyst w/scope	C
62163	Neuroendoscopy w/fb removal	C
62164	Remove brain tumor w/scope	C
62165	Remove pituit tumor w/scope	C
62180	Establish brain cavity shunt	C
62190	Establish brain cavity shunt	C
62192	Establish brain cavity shunt	C
62200	Establish brain cavity shunt	C
62201	Brain cavity shunt w/scope	C
62220	Establish brain cavity shunt	C
62223	Establish brain cavity shunt	C
62256	Remove brain cavity shunt	C
62258	Replace brain cavity shunt	C
63043	Laminotomy, add'l cervical	C
63044	Laminotomy, add'l lumbar	C
63050	Cervical laminoplasty	C
63051	C-laminoplasty w/graft/plate	C
63076	Neck spine disk surgery	C
63077	Spine disk surgery, thorax	C
63078	Spine disk surgery, thorax	C
63081	Removal of vertebral body	C
63082	Remove vertebral body add-on	C
63085	Removal of vertebral body	C
63086	Remove vertebral body add-on	C
63087	Removal of vertebral body	C
63088	Remove vertebral body add-on	C
63090	Removal of vertebral body	C
63091	Remove vertebral body add-on	C
63101	Removal of vertebral body	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
63102	Removal of vertebral body	C
63103	Remove vertebral body add-on	C
63170	Incise spinal cord tract(s)	C
63172	Drainage of spinal cyst	C
63173	Drainage of spinal cyst	C
63180	Revise spinal cord ligaments	C
63182	Revise spinal cord ligaments	C
63185	Incise spinal column/nerves	C
63190	Incise spinal column/nerves	C
63191	Incise spinal column/nerves	C
63194	Incise spinal column & cord	C
63195	Incise spinal column & cord	C
63196	Incise spinal column & cord	C
63197	Incise spinal column & cord	C
63198	Incise spinal column & cord	C
63199	Incise spinal column & cord	C
63200	Release of spinal cord	C
63250	Revise spinal cord vessels	C
63251	Revise spinal cord vessels	C
63252	Revise spinal cord vessels	C
63265	Excise intraspinal lesion	C
63266	Excise intraspinal lesion	C
63267	Excise intraspinal lesion	C
63268	Excise intraspinal lesion	C
63270	Excise intraspinal lesion	C
63271	Excise intraspinal lesion	C
63272	Excise intraspinal lesion	C
63273	Excise intraspinal lesion	C
63275	Biopsy/excise spinal tumor	C
63276	Biopsy/excise spinal tumor	C
63277	Biopsy/excise spinal tumor	C
63278	Biopsy/excise spinal tumor	C
63280	Biopsy/excise spinal tumor	C
63281	Biopsy/excise spinal tumor	C
63282	Biopsy/excise spinal tumor	C
63283	Biopsy/excise spinal tumor	C
63285	Biopsy/excise spinal tumor	C
63286	Biopsy/excise spinal tumor	C
63287	Biopsy/excise spinal tumor	C
63290	Biopsy/excise spinal tumor	C
63295	Repair of laminectomy defect	C
63300	Removal of vertebral body	C
63301	Removal of vertebral body	C
63302	Removal of vertebral body	C
63303	Removal of vertebral body	C
63304	Removal of vertebral body	C
63305	Removal of vertebral body	C
63306	Removal of vertebral body	C
63307	Removal of vertebral body	C
63308	Remove vertebral body add-on	C
63700	Repair of spinal herniation	C
63702	Repair of spinal herniation	C
63704	Repair of spinal herniation	C
63706	Repair of spinal herniation	C
63707	Repair spinal fluid leakage	C
63709	Repair spinal fluid leakage	C
63710	Graft repair of spine defect	C
63740	Install spinal shunt	C
64752	Incision of vagus nerve	C
64755	Incision of stomach nerves	C
64760	Incision of vagus nerve	C
64809	Remove sympathetic nerves	C
64818	Remove sympathetic nerves	C
64866	Fusion of facial/other nerve	C
64868	Fusion of facial/other nerve	C
65273	Repair of eye wound	C
69155	Extensive ear/neck surgery	C
69535	Remove part of temporal bone	C

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	Description	CY 2007 Proposed Rule Status Indicator
69554	Remove ear lesion	C
69950	Incise inner ear nerve	C
69970	Remove inner ear lesion	C
75900	Intravascular cath exchange	C
75952	Endovasc repair abdom aorta	C
75953	Abdom aneurysm endovas rpr	C
75954	Iliac aneurysm endovas rpr	C
75956	Xray, endovasc thor ao repr	C
75957	Xray, endovasc thor ao repr	C
75958	Xray, place prox ext thor ao	C
75959	Xray, place dist ext thor ao	C
92970	Cardioassist, internal	C
92971	Cardioassist, external	C
92975	Dissolve clot, heart vessel	C
92992	Revision of heart chamber	C
92993	Revision of heart chamber	C
99190	Special pump services	C
99191	Special pump services	C
99192	Special pump services	C
99251	Initial inpatient consult	C
99252	Initial inpatient consult	C
99253	Initial inpatient consult	C
99254	Initial inpatient consult	C
99255	Initial inpatient consult	C
99293	Ped critical care, initial	C
99294	Ped critical care, subseq	C
99295	Neonate crit care, initial	C
99296	Neonate critical care subseq	C
99298	Ic for lbw infant < 1500 gm	C
99299	Ic, lbw infant 1500-2500 gm	C
99356	Prolonged service, inpatient	C
99357	Prolonged service, inpatient	C
99433	Normal newborn care/hospital	C
0021T	Fetal oximetry, trnsvag/cerv	C
0024T	Transcath cardiac reduction	C
0048T	Implant ventricular device	C
0049T	External circulation assist	C
0050T	Removal circulation assist	C
0051T	Implant total heart system	C
0052T	Replace component heart syst	C
0053T	Replace component heart syst	C
0075T	Perq stent/chest vert art	C
0076T	S&i stent/chest vert art	C
0077T	Cereb therm perfusion probe	C
0078T	Endovasc aort repr w/device	C
0079T	Endovasc visc extnsn repr	C
0080T	Endovasc aort repr rad s&i	C
0081T	Endovasc visc extnsn s&i	C
0090T	Cervical artific disc	C
0091T	Lumbar artific disc	C
0092T	Artific disc addl	C
0093T	Cervical artific diskectomy	C
0094T	Lumbar artific diskectomy	C
0095T	Artific diskectomy addl	C
0096T	Rev cervical artific disc	C
0097T	Rev lumbar artific disc	C
0098T	Rev artific disc addl	C
0153T	Implant aneur sensor add-on	C
G0341	Percutaneous islet celltrans	C
G0342	Laparoscopy islet cell trans	C
G0343	Laparotomy islet cell transp	C

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