DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410 and 416

[CMS–1517–F]

RIN 0938–AO73

Medicare Program; Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs) Beginning in CY 2008

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

ACTION: Final rule.

SUMMARY: This final rule revises the Medicare ambulatory surgical center (ASC) payment system to implement certain related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This final rule establishes the ASC list of covered surgical procedures, identifies covered ancillary services under the revised ASC payment system, and sets forth the amounts and factors that will be used to determine the ASC payment rates for calendar year (CY) 2008. The changes to the ASC payment system and ratesetting methodology in this final rule are applicable to services furnished on or after January 1, 2008.

DATES: *Effective Date:* This final rule is effective on January 1, 2008.

FOR FURTHER INFORMATION, CONTACT: Alberta Dwivedi, (410) 786–0378. Dana Burley, (410) 786–0378.

SUPPLEMENTARY INFORMATION:

Electronic Access

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

Alphabetical List of Acronyms Appearing in This Final Rule

AHA American Hospital Association
AMA American Medical Association
APC Ambulatory payment classification
ASC Ambulatory surgical center
BESS [Medicare] Part B Extract Summary System
CAH Critical access hospital
CBSA Core-Based Statistical Area
CMS Centers for Medicare & Medicaid Services
CPI–U Consumer Price Index for All Urban Consumers
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2007, copyrighted by the American Medical Association. CPT® is a trademark of the American Medical Association.
CY Calendar year
DRA Deficit Reduction Act of 2005, Public Law 109–171
FY Federal fiscal year
GAO Government Accountability Office
HCPCS Healthcare Common Procedure Coding System
HOPD Hospital outpatient department
HQA Hospital Quality Alliance
IOL Intraocular lens
IPPS [Hospital] Inpatient prospective payment system
MAC Medicare administrative contractor
MedPAC Medicare Payment Advisory Commission
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173
MPFS Medicare Physician Fee Schedule
MSA Metropolitan Statistical Area
NTIOL New technology intraocular lens
OCE Outpatient Code Editor
OMB Office of Management and Budget
OPPS [Hospital] Outpatient prospective payment system
PM Program memorandum
PPAC Practicing Physicians Advisory Council
PPS Prospective payment system
PRA Paperwork Reduction Act of 1995
RFA Regulatory Flexibility Act
RVU Relative value unit

To assist readers in referencing sections contained in this document, we are providing the following table of contents:

Table of Contents

I. Background

A. Legislative and Regulatory History

Section 1832(a)(2)(F)(i) of the Social Security Act (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 specified by the Secretary that are performed in an ambulatory surgical center (ASC). To participate in the Medicare program as an ASC, a facility must meet the standards specified in section 1832(a)(2)(F)(i) of the Act, which are implemented in 42 CFR Part 416, Subpart B and Subpart C of our regulations. The regulations at 42 CFR 416, Subpart B set forth general conditions and requirements for ASCs, and the regulations at Subpart C provide specific conditions for coverage for ASCs.

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 1833(i)(1)(A) of the Act requires the Secretary to specify surgical procedures that, although appropriately performed in an inpatient hospital setting, also can be performed safely on an ambulatory basis in an ASC, critical access hospital (CAH), or a hospital outpatient department (HOPD). The report accompanying the legislation explained that 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 on 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. Medicare only allows payment to ASCs for procedures that are specified on the ASC list.

Section 626(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173, repealed the requirement formerly found in section 1833(i)(2)(A) of the Act that the Secretary conduct a survey of ASC costs for purposes of updating ASC payment rates and, instead, requires the Secretary to implement a revised ASC payment system, to be effective not later than January 1, 2008. Section 5103 of the Deficit Reduction Act of 2005 (DRA), Public Law 109–171, amended section 1833(i)(2) of the Act by adding a new subparagraph (E) to place a limitation on payments for surgical procedures in ASCs. Section 1833(i)(2) of the Act provides that 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 payment amount under the hospital outpatient prospective payment system (OPPS) for the service for that year, without application of any geographic adjustment, the Secretary shall substitute the OPPS payment amount for the ASC standard overhead amount. This provision applies to surgical procedures furnished in ASCs on or after January 1, 2007, and before the effective date of the revised ASC payment system implemented in this final rule.

In the November 24, 2006 final rule with comment period for the CY 2007 OPPS and ASC payment systems (71 FR 67960), we addressed the changes in payment to ASCs mandated by section 5103 of Public Law 109–171 and finalized § 416.1(a)(5) of the regulations to implement this provision. (Hereinafter, the November 24, 2006 final rule with comment period is referred to as the CY 2007 OPPS/ASC final rule with comment period.) We also addressed additions to and deletions from the ASC list of covered surgical procedures that were implemented on January 1, 2007. In addition, we made changes in the process to review payment adjustments for insertion of new technology intraocular lenses (NTIOLs) under section 1833(i)(2)(A)(iii) of the Act.

Section 416.65(a) of the regulations specifies general standards for procedures on the ASC list. ASC procedures are those surgical and other medical 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 postoperative 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 can be found in the June 12, 1998 proposed rule (63 FR 32291). 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), May 4, 2005 (70 FR 23690), and in the CY 2007 OPPS/ASC final rule with comment period (71 FR 67960).

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 the Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. These annual coding updates have been implemented through program instructions to the carriers that process ASC claims. (We note that Medicare Part B carriers are transitioning to Medicare Administrative Contractors (MACs) through 2011, as described in a final rule with comment period published in the **Federal Register** on November 24, 2006 (71 FR 68229).) We last issued program instructions to update the list only to conform to CPT and HCPCS coding changes on December 20, 2006, via Transmittal 1134, Change Request 5211. This transmittal can be found on the CMS Web site at: *http://www.cms.hhs.gov/Transmittals/*).

B. ASC Payment Method

On August 23, 2006, we proposed in the **Federal Register** (71 FR 49635) a revised payment system for ASCs to be implemented effective January 1, 2008, in accordance with section 626(b) of Public Law 108–173, including revisions to the ratesetting methodology and the applicable ASC regulations to incorporate the requirements and payments for ASC services under the revised ASC payment system. We also proposed a new ''exclusionary'' approach for revising the ASC list of covered surgical procedures beginning CY 2008. We proposed to evaluate surgical procedures to identify those that could pose a significant safety risk or that would be expected to require an overnight stay when performed in ASCs, and that would, therefore, be excluded from Medicare payment under the revised ASC payment system. Using that exclusionary method, we developed a list of surgical procedures that we believed were safe for Medicare beneficiaries in ASCs and that were appropriate for Medicare payment. We proposed to adopt an exclusionary approach for identifying surgical procedures that were appropriate for payment under the revised ASC payment system, and the result of that process was a proposed list of surgical procedures for which separate payment would be made. We refer to that list of payable procedures hereinafter as the ASC ''list of covered surgical procedures.''

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 (MPFS). The August 2006 OPPS/ASC proposed rule addressed the second element, payment for the cost of items and services furnished by the facility.

Under the current ASC 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 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. Rept. No. 96–1479, at 134–35 (1980)).

As stated earlier, to establish those reasonable estimated allowances for services furnished prior to implementation of the revised ASC payment system, section 626(b)(1) of Public Law 108–73 amended section 1833(i)(2)(A)(i) of the Act that required us to take into account the audited costs incurred by ASCs to perform a procedure in accordance with a survey. Further, beginning January 1, 2007, and prior to implementation of a revised ASC payment system, in accordance with section 5103 of Pub. L. 109–171, no ASC standard overhead amount may be greater than the OPPS payment rate for a given service for that year. Except for screening colonoscopies and flexible sigmoidoscopies, payment for ASC 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 overhead amount. As required by section 1834(d) of the Act and implemented in regulations at 42 CFR 410.152(i), the amount paid by Medicare must be 75 percent of the fee schedule payment amount for screening colonoscopies and flexible sigmoidoscopies.

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, a CAH, or an HOPD and to review and update the list of ASC procedures at least every 2 years.

Section 141(b) of the Social Security Act Amendments of 1994, Public Law 103–432, requires us to establish a process for reviewing the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for intraocular lenses (IOLs) that belong to 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 on June 16, 1999, in the **Federal Register** (64 FR 32198). We proposed changes to the NTIOL request for review process in the CY 2007 OPPS/ASC proposed rule published in the **Federal Register** on August 23, 2006 (71 FR 49631 through 49635) and finalized changes to that process in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68175 through 68181).

C. Provisions of Public Law 108–173 (MMA)

Section 626(a) of Public Law 108–173 (MMA) 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 (CPI–U) (U.S. city average) if the Secretary has not otherwise updated the amounts under the revised ASC payment system. As amended by Pub. L. 108–173, section 1833(i)(2)(C) of the Act 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 (FY) basis beginning with FY 1986 through FY 2005 and on a

calendar year (CY) basis beginning with CY 2006.

Section 626(a) of Public Law 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. Section 626(a) of Public Law 108–173 also requires that the CPI–U adjustment factor equal zero percent in FY 2005, the last quarter of CY 2005, and each calendar year from CY 2006 through CY 2009.

Section 626(b) of Public Law 108–173 repealed 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 added section 1833(i)(2)(D) of the Act. Section 1833(i)(2)(D)(iii) of the Act 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 Government Accountability Office (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 Public Law 109–171 beginning January 1, 2007, as we described in sections XVII.A.1. and XVII.E. of the preamble to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68165 and 68174, respectively).

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 Public Law 108–173 added a conforming amendment to section 1833(a)(1) of the Act, which provides 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 under the revised ASC payment system.

D. Issuance of Proposed Rule

As stated earlier, in the August 23, 2006 **Federal Register** (71 FR 49635), we proposed to implement revisions to the ASC payment system so that the revised system is first effective on January 1, 2008.

In addition, we set forth an analysis of the impact that the proposed revised ASC payment system would have on affected entities and Medicare beneficiaries.

We received over 8,900 pieces of correspondence in response to our August 23, 2006 proposal for the revised ASC payment system, which included some comments recommending various changes to how CMS pays for ASC services and processes ASC claims that we did not propose in the August 23, 2006 **Federal Register**. While we read those comments with interest, we generally do not address them, nor have we made any changes in this final rule based on them. We summarize the numerous comments and recommendations that are pertinent to what we proposed, and we respond to them in the appropriate sections of this final rule.

E. Changes to the ASC List for CY 2007

As part of the CY 2007 OPPS/ASC final rule with comment period, we finalized additions to and deletions from the ASC list of covered surgical procedures, effective January 1, 2007 (71 FR 68166). We did not change the criteria for adding or deleting items from the ASC list effective January 1, 2007. However, in the August 2006 proposed rule (71 FR 49628), we discussed changes to the criteria in the context of developing the proposed revised ASC payment system to be effective January 1, 2008. The changes to the criteria that we proposed resulted in the proposed addition for CY 2008 of many procedures that do not meet the current criteria for addition to the list.

II. Revisions to the ASC Payment System Effective January 1, 2008

A. General

As we discussed earlier, generally, there are two primary elements in the total cost of performing a surgical procedure: (a) The cost of the physician's professional services for performing the procedure; and (b) 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 MPFS. The latter is covered by a Medicare benefit enacted in 1980 that authorized payment of a fee to ASCs for services furnished in connection with performing certain surgical procedures.

Section 1833(i)(1) of the Act requires us to specify surgical procedures that are appropriately and safely performed on an ambulatory basis in an ASC. Moreover, we are required 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 of covered surgical procedures 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 performed under the present ASC payment system.

In CY 2007, Medicare only allows payment to ASCs for procedures on the ASC list of covered surgical procedures. Except for screening colonoscopy services, payment for ASC facility services is subject to the usual Medicare Part B deductible and coinsurance requirements, and the amounts paid by Medicare must be 80 percent of the standard overhead amount. As discussed earlier, under section 626(b) of Public Law 108–173, Congress mandated implementation of a revised payment system for ASC surgical services by no later than January 1, 2008. Public Law 108–173 set forth several requirements for the revised payment system, but did not amend those provisions of the statute pertaining to the ASC list.

As we proposed in the August 2006 proposed rule (71 FR 49635), in this final rule, we address two components of the ASC payment system that will go into effect January 1, 2008. First, we are establishing the ASC list of covered surgical procedures for which an ASC may receive Medicare payment for facility services under the revised ASC payment system, as well as those covered ancillary services that may be separately paid if they are provided integral to a covered surgical procedure. Second, we are specifying the method we will use to set payment rates for ASC services furnished in association with covered surgical procedures. In this final rule, we also specify the regulatory changes that we are making to 42 CFR Parts 410 and 416 to incorporate the rules governing ASC payments that will be applicable beginning in CY 2008.

B. Factors Considered in the Development of the Revised ASC Payment System

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 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 revised payment system, as well as developing a process to allow special payment for new technology.

We 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 revised payment system. We appreciate the thoughtful suggestions that were presented. We considered the concerns and issues brought to our attention, the proposals for revising the ASC list of covered surgical procedures, and the suggested methods by which we could set ASC payment rates in developing the policies in this final rule.

In the August 23, 2006 **Federal Register** (71 FR 49506), we proposed the policies for the revised ASC payment system to be effective beginning in CY 2008. In response to those proposed policies, we received over 8,900 pieces of correspondence from the public that we are addressing in this final rule.

Subsequent to publication of the August 2006 proposed rule for the revised ASC payment system, the GAO published the statutorily mandated report entitled, ''Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System'' (GAO–07–86) on November 30, 2006. We considered the report's methodology, findings, and recommendations in the development of this CY 2008 final rule for the revised ASC payment system. The GAO methodology, results, and recommendations are summarized below.

The GAO was directed to conduct a study comparing the relative costs of procedures furnished in ASCs to those furnished in HOPDs paid under the OPPS, including examining the accuracy of the ambulatory payment classifications (APC) with respect to surgical procedures furnished in ASCs. Section 626(d) of Pub. L. 108–173 indicated that the report should include recommendations on the following matters:

1. Appropriateness of using groups of covered services and relative weights established for the OPPS as the basis of payment for ASCs.

2. If the OPPS relative weights are appropriate for this purpose, whether the ASC payments should be based on a uniform percentage of the payment rates or weights under the OPPS, or should vary, or the weights should be revised based on specific procedures or types of services.

3. Whether a geographic adjustment should be used for ASC payment and, if so, the labor and nonlabor shares of such payment.

To compare the relative costs of procedures performed in ASCs and HOPDs, the GAO first compiled information on ASCs' costs and the surgical procedures performed. It conducted a survey of 600 randomly selected ASCs from the universe of all ASCs to obtain their CY 2004 cost and procedure data. The GAO received 397 responses from facilities and, through data reliability testing, determined that data from 290 responding facilities were sufficiently reliable and geographically representative of ASCs. Furthermore, to compare the delivery of surgical procedures and their relative costs between ASC and HOPD settings, the GAO analyzed OPPS claims data from CY 2003. It also interviewed officials at CMS, representatives from ASC industry organizations and physician specialty societies, and representatives from nine ASCs.

In order to allocate ASCs' total costs among the individual procedures they performed, the GAO developed a specific methodology to allocate the portion of an ASC's costs accounted for by each procedure. It constructed a relative weight scale for Medicare's covered ASC procedures that captured the general variation in resources associated with performing different procedures. Primarily, it used data that CMS collects for the purpose of setting the practice expense component of physician payment rates, supplemented by information from specialty societies and physicians who work for CMS for those procedures for which CMS had no data on the resources used.

To calculate per-procedure costs based upon data gathered through its survey of ASCs, the GAO deducted costs that Medicare considers unallowable, that is, advertising and entertainment costs. In addition, it also removed costs for services that Medicare pays for separately, such as physician and nonphysician practitioner services. The remaining facility costs were then divided into direct and indirect costs. The GAO defined direct costs as those associated with the clinical staff, equipment, and supplies utilized during the procedure. Indirect costs included all remaining costs. Next, to allocate each facility's direct costs across the procedures it performed, the GAO applied its relative weight scale. It allocated indirect costs equally across all procedures performed by the facility. For each procedure performed by a responding ASC facility, it summed the allocated direct and indirect costs to determine a total cost for the procedure. To obtain a per-procedure cost across all ASCs, the GAO arrayed the calculated costs for all ASCs performing that procedure and identified the median cost.

To compare per-procedure costs for ASCs and HOPDs, the GAO obtained the list of OPPS APCs and their assigned procedures, along with the OPPS median cost of each procedure and its related APC group. It then calculated a ratio between each procedure's ASC median cost as determined by the survey and the median cost of the procedure's corresponding APC group under the OPPS, referred to as the ASC-to-APC cost ratio. It calculated a corresponding ratio between each ASC procedure's median cost under the OPPS and the median cost of the procedure's APC group using CMS data, referred to as the OPPS-to-APC cost ratio. In order to evaluate the difference in procedure costs between the two settings, the GAO compared the ASC-to-APC cost ratio to the OPPS-to-APC cost ratio. Next, to assess how well the relative costs of procedures in the OPPS, defined by their assignment to APC groups, reflect the relative costs of procedures in the ASC setting, it evaluated the distribution of both the ASC-to-APC cost ratios and the OPPS-to-APC cost ratios.

The GAO also analyzed Medicare claims data for the top 20 procedures with the highest Medicare ASC claims volume in CY 2004 to examine the delivery of additional services with

surgical procedures in ASCs and HOPDs. Last, to calculate the percentage of labor-related costs among the responding ASCs, for each ASC, the GAO divided total labor costs by total costs and then determined the range of the percentage of labor-related costs among all of the ASCs between the 25th and the 75th percentile, as well as the mean and median percentage of labor-related costs.

Based on its extensive analyses, the GAO determined that the APC groups in the OPPS accurately reflect the relative costs of the procedures performed in ASCs. GAO's analysis of the cost ratios showed that the ASC-to-APC cost ratios were more tightly distributed around their median cost ratio than were the OPPS-to-APC cost ratios. These patterns demonstrated that the APC groups reflect the relative costs of procedures performed by ASCs and, therefore, that the APC groups could be used as the basis for an ASC payment system. The GAO determined, in fact, that there was less variation in the ASC setting between individual procedures' costs and the costs of their assigned APC groups than there is in the HOPD setting. It concluded that, as a group, the costs of procedures performed in ASCs have a relatively consistent relationship with the costs of the APC groups to which they would be assigned under the OPPS. The GAO's analysis also found that procedures in the ASC setting had substantially lower costs than those same procedures in the HOPD. While ASC costs for individual procedures varied, in general, the median costs for procedures were lower in ASCs, relative to the median costs of their APC groups, than the median costs for the same procedures in the HOPD setting. The median cost ratio among all ASC procedures was 0.39 (0.84 when weighted by Medicare volume based on CY 2004 claims), whereas the median cost ratio among all OPPS procedures was 1.04.

The GAO found many similarities in the additional items and services provided by ASCs and HOPDs for the top 20 ASC procedures. However, of these additional items and services, few resulted in additional payment in one setting but not the other. HOPDs were paid for some of the related services separately, while in the ASC setting, other Part B suppliers billed Medicare and received payment for many of the related services.

Finally, in its analysis of labor-related costs, the GAO determined that the mean labor-related proportion of costs was 50 percent. The range of the labor-related costs for the middle 50 percent of responding ASCs was 43 percent to 57 percent of total costs.

Based on its findings from the study, the GAO recommended that CMS implement a payment system for procedures performed in ASCs based on the OPPS, taking into account the lower relative costs of procedures performed in ASCs compared to HOPDs in determining ASC payment rates.

Comment: A number of commenters noted that, by the close of the public comment period for the August 2006 proposed rule for the revised ASC payment system, the GAO had not yet provided recommendations regarding ASC payment in a report to Congress that it was required to submit by January 1, 2005. Some commenters recommended that, although CMS was directed to take into account these recommendations in implementing the revised ASC payment system, should the GAO's recommendations be provided before publication of the final rule establishing the policies of the revised ASC payment system, CMS should not take them into consideration, given the public's inability to provide input to CMS during the comment period regarding the GAO's methodology, findings, and recommendations. Other commenters recommended that, if the GAO Report was forthcoming shortly, CMS should provide another opportunity for public comment prior to finalizing the policies of the revised ASC payment system in order to allow the public to provide CMS with their perspectives on those recommendations.

Response: As described earlier, the GAO published its report (GAO–07–86) on November 30, 2006. In accordance with section 1833(i)(2)(D)(i) of the Act, we did take into account the recommendations made in the GAO Report in developing the final policies for the revised ASC payment system. The GAO's findings and recommendations are summarized above, and its specific recommendations are further discussed in the particular sections of this final rule that address the related topics. We appreciate the public's interest in providing us with detailed input regarding the revised ASC payment system from a variety of perspectives. In regard to the commenters' recommendation for a second opportunity for public comment prior to finalizing the policies of the revised ASC payment system after the GAO Report was published, we note that the GAO's recommendations are in complete accord with our August 2006 proposal for the revised ASC payment system. Therefore, we are not providing another opportunity for public comment prior to finalizing the policies of the revised ASC payment system, because the proposed revised system is fully consistent with the recommendations of the GAO Report and we already provided a 90-day comment period regarding our proposal for CY 2008. We believe that the comment period for the August 2006 proposed rule provided the public with ample opportunity to comment on the policies that were recommended by the GAO. The considerable operational changes required to implement the revised ASC payment system necessitate significant lead time that would not be possible if we were to provide another comment period prior to finalizing the policies. We also believe that our consideration of the recent GAO study, as well as other available information regarding HOPD and ASC costs and payments, in addition to our prior discussions with stakeholders and the many public comments on the proposed rule, provide us with the necessary breadth and depth of information and viewpoints to finalize our payment policies for the revised ASC payment system in this final rule.

At its December 2006 meeting, the Practicing Physicians Advisory Council (PPAC) made two recommendations to CMS regarding the final rule for the revised ASC payment system. First, the PPAC recommended that CMS establish a process to consult with national medical specialty societies and the ASC community to develop and adopt a systematic and adaptable means of fairly reimbursing ASCs for all safe and appropriate services, allowing for changes in technology and current day practice. Second, the PPAC recommended that CMS apply any payment policies uniformly to both ASCs and HOPDs, as appropriate.

We have considered the GAO Report, in addition to the recommendations of the PPAC, all public comments received on the proposed rule, and other concerns and issues brought to our attention by interested parties over the past several years, in developing this final rule for the CY 2008 revised ASC payment system. Specific policies are discussed, comments summarized and responses provided, and policies finalized in subsequent sections of this final rule.

C. Rulemaking for the Revised ASC Payment System in CY 2008

In response to comments submitted timely regarding the proposals set forth in the proposed rule for the revised ASC payment system published on August 23, 2006, this final rule establishes the final policies and regulations of the

revised ASC payment system for initial implementation in CY 2008. All tables included in this final rule listing HCPCS codes subject to pertinent final policies of the revised ASC payment system, as well as estimated payment rates, are illustrative only, based on CY 2007 HCPCS codes and final CY 2007 OPPS and MPFS information, with application of the most current update estimates for CY 2008. The information in the Addenda to this final rule is also only illustrative, to provide examples of the results of applying the final policies of the revised ASC payment system, based on the most recent information available for CY 2007. As further discussed in sections V.E. and VI. of this final rule, we will propose the CY 2008 relative payment weights, payment amounts, specific HCPCS codes to which the final policies of the revised ASC payment system would apply, and other pertinent ratesetting information for the CY 2008 revised ASC payment system in the proposed OPPS/ASC rule to update the payment systems for CY 2008 to be issued in mid-summer of CY 2007. We will then publish final relative payment weights, payment amounts, specific CY 2008 HCPCS codes to which the final policies will apply, and other pertinent ratesetting information for the CY 2008 revised ASC payment system in the final OPPS/ASC rule to update the payment systems for CY 2008. The ASC payment system treatment of new CY 2008 HCPCS codes published in the CY 2008 OPPS/ASC final rule will provide interim determinations, open to public comment on that final rule, and we will respond to comments about those determinations in the OPPS/ASC final rule for CY 2009.

III. Covered Surgical Procedures Paid in ASCs On or After January 1, 2008

A. Payable Procedures

In its March 2004 Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) recommended replacing the current ''inclusive'' list of procedures, which are the only surgical procedures for which Medicare allows payment to an ASC, with an ''exclusionary'' list. That is, rather than limiting payment to ASCs to a list of procedures that CMS specifies, Medicare would allow payment to ASCs 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 eligibility for Medicare ASC payment. 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 of covered surgical procedures, are probably no longer clinically relevant.

In the August 2006 proposed rule for the revised ASC payment system, we noted that we had 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 for payment under the revised ASC payment system. We agreed that adoption of a policy similar to 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, in the August 2006 proposed rule (71 FR 49636), we proposed that, under the revised ASC payment system for services furnished on or after January 1, 2008, Medicare would allow payment to ASCs for any surgical procedure performed in an ASC, except those surgical procedures that we determine are not payable under the ASC benefit.

Further, we proposed to establish beneficiary safety and the expected need for an overnight stay as the principal clinical considerations and decisive factors in determining whether ASC payment would be allowed for a particular surgical procedure. As discussed in section XVIII.B.2. of the preamble of the proposed rule, we also proposed to exclude from separate payment under the revised ASC payment system those surgical procedures that are on the OPPS inpatient list, that are not eligible for separate payment under the OPPS, and that are CPT surgical unlisted procedure codes.

We discuss below the criteria that we proposed 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.

1. Definition of Surgical Procedure

In order to delineate the scope of procedures that constitute ''outpatient surgical procedures'' in the August 2006 proposed rule, we first proposed to clarify what we considered to be a ''surgical'' procedure. Under the existing ASC payment system, we define a surgical procedure as any procedure described within the range of Category I CPT codes that the CPT Editorial Panel of the American Medical Association (AMA) defines as ''surgery'' (CPT codes 10000 through 69999). Under the revised payment system, we proposed to continue to define surgery using that standard. The CPT Editorial Panel is responsible for maintaining the CPT nomenclature, with authority to revise, update, or modify the CPT codes. A larger body of CPT advisors, the CPT Advisory Committee, supports the work of the CPT Editorial Panel. Members of the CPT Editorial Panel include individuals nominated by physician and hospital associations and insurers, providing for diverse specialty input.

In addition, in the August 2006 proposed rule for the revised ASC payment system, we proposed to include within the scope of surgical procedures payable in an ASC those procedures that are described by Level II HCPCS codes or by Category III CPT codes that directly crosswalk to or are clinically similar to procedures in the CPT surgical range. We proposed to include all three types of codes in our definition of surgical procedures because they all may be eligible for separate payment under the OPPS and, to the extent it is reasonable to do so, we proposed that the revised ASC payment system parallel the OPPS in its policies.

In the August 2006 proposed rule, we provided an example of a Level II HCPCS code that we believe represents a procedure that could be safely and appropriately performed in an ASC, specifically HCPCS code G0297 (Insertion of single chamber pacing cardioverter-defibrillator pulse generator). We developed this Level II HCPCS code for use in the OPPS because CPT code 33240 (Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator), which describes the surgical insertion of a cardioverter-defibrillator pulse generator, does not distinguish insertion of a single chamber cardioverter-defibrillator generator from insertion of a dual chamber cardioverter-defibrillator generator. Under the OPPS, 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 Level II HCPCS codes to permit HOPDs to more accurately report the resources required when these surgical procedures are performed. In instances such as this, when a 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 proposed to allow payment for the Level II HCPCS code under the proposed revised ASC payment system. We proposed not to allow ASC payment for Level II HCPCS codes or Category III CPT codes that describe services that fall outside the scope of, that is, that do not correspond to, surgical procedures described by CPT codes 10000 through 69999.

We recognized in the proposed rule that continuing to use this definition of surgery would exclude from ASC payment 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 believed that continuing to rely on the CPT definition of surgery would be administratively straightforward, logically related to the categorization of services by physician experts who both establish the codes and perform the procedures, and consistent with our proposal to allow ASC payment for all outpatient surgical procedures. Given the number of other changes that we expected to implement as part of the revised payment system, along with the significant expansion of ASC covered surgical procedures that we proposed, we explained that we believed 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 MPFS and the OPPS. During the development of the August 2006 proposed rule, we reviewed thousands of CPT codes in the surgical range (CPT codes 10000 through 69999), and we proposed to not exclude from payment over 750 surgical procedures previously excluded, in addition to providing ASC payment for the more than 2,500 CPT codes on the CY 2007 ASC list of covered surgical procedures.

However, we are cognizant of the dynamic nature of ambulatory surgery, which has resulted in a dramatic shift of services from the inpatient setting to the outpatient setting over the past two decades. Therefore, in the proposed rule, we solicited comments regarding other services that are invasive and ''surgery-like,'' which could safely and appropriately be performed in 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 were interested in considering commenters' views regarding what constitutes a ''surgical'' procedure.

We received many public comments about our August 2006 proposal to define the surgical procedures for which we would make payment to ASCs as those falling within the surgical code range specified by the CPT Editorial Panel.

Comment: While, in general, hospital associations and device manufacturers supported the proposal to maintain the definition of a surgical procedure used under the existing ASC payment system, many ASC industry representatives provided a broad range of suggestions about how the definition should be expanded. Some of the commenters requested that CMS place no limit on the procedures that would be payable in ASCs because there is no such limit on Medicare payments to HOPDs. Other commenters suggested a more limited expansion of procedures eligible for payment under the revised ASC payment system. These commenters specifically recommended that CMS expand its definition of a surgical procedure to include:

(a) Medical procedures that are invasive and require general anesthesia or that are specifically designated as intraoperative procedures;

(b) X-ray, fluoroscopy, and ultrasound procedures that require insertion of a needle, catheter, tube, or probe via a natural orifice or through the skin;

(c) Radiology procedures integral to performance of nonradiologic procedures, performed either during or immediately following the surgical procedure; and

(d) Level II HCPCS and Category III CPT codes that describe procedures that crosswalk directly or are clinically similar to those listed in suggestions (a) through (c) above.

Response: We have given consideration to the many recommendations of the commenters. In general, we continue to believe it is appropriate to provide payments to ASCs for the resources associated with performing those services that are surgical procedures as defined by the CPT Editorial Panel. From the Panel's broad experience in regularly addressing the complex issues associated with new and emerging health care technologies, as well as the difficulties encountered with obsolete procedures, we believe its members are well-positioned to maintain and refine the existing coding taxonomy, which defines certain procedures as surgery, to appropriately reflect medical practice in an evolving health care delivery system. In addition, we believe that our proposal to pay for surgical procedures in ASCs that are reported by Level II HCPCS and Category III CPT codes that directly crosswalk or are clinically similar to procedures in the surgical range of CPT codes that are payable in ASCs is consistent with our definition of surgery according to the CPT surgical code range, while providing ASC payment for some procedures that have not yet been categorized by the CPT Editorial Panel or for which Medicare recognizes alternative HCPCS codes for payment.

Although we are not changing our definition of surgery as suggested by commenters, we did review procedures that are coded by specific Level II HCPCS or Category III CPT codes that were identified by commenters as surgical procedures that should be payable in ASCs. We assessed those procedures using the same final criteria discussed in section III.A.2. of this final rule that we used to evaluate all surgical procedures for their safety or the expected need for an overnight stay in making decisions about their exclusion from ASC payment. As we proposed, we also evaluated the codes in the context of whether they directly crosswalk or are clinically similar to procedures in the CPT surgical range that we have determined do not pose a significant safety risk or for which an overnight stay is not expected when performed in ASCs. As a result of that review, 14 additional Level II HCPCS codes and 15 Category III CPT codes beyond those we proposed for CY 2008 payment will be payable as covered surgical procedures when performed in ASCs beginning in CY 2008.

Furthermore, as discussed in section IV. of this final rule, although we are not expanding our definition of surgical procedures, we will provide separate ASC payment for a number of covered ancillary services when they are furnished on the same day as a covered surgical procedure and are integral to the performance of that procedure in the ASC setting. Those services include certain radiology procedures, such as some fluoroscopy and ultrasound services, that some commenters recommended we define as surgical procedures for addition to the ASC list of covered surgical procedures.

Comment: Several commenters expressed concern regarding CMS' proposed exclusion from ASC payment of all procedures described within the range of Category I CPT codes defined as ''radiology'' in accordance with the CPT Editorial Panel designation. The commenters asserted that regulations regarding the Federal physician self-referral prohibition (section 1877 of the Act) exclude interventional and

intraoperative radiology services from the definition of ''radiology'' services subject to the law's self-referral prohibition, and that CMS should, therefore, treat those services as surgical services that are eligible for payment as covered surgical procedures under the revised ASC payment system. They believed that interventional radiology and intraoperative radiology services that require insertion of a needle, catheter, tube, probe, or similar device are appropriately considered surgical in nature for purposes of ASC payment.

Response: The commenters' statements with respect to the treatment of interventional radiology procedures under the physician self-referral regulations seem overly broad. The physician self-referral regulations provide that the following services (which may include some, but not all, interventional radiology procedures) are not ''radiology and certain other imaging services'' for purposes of section 1877 of the Act: (i) X-ray, fluoroscopy, or ultrasound procedures that require the insertion of a needle, catheter, tube, or probe through the skin or into a body orifice; and (ii) radiology procedures that are integral to the performance of a nonradiological medical procedure and performed either during the nonradiological medical procedure or immediately following the nonradiological medical procedure when necessary to confirm placement of an item inserted during the nonradiological medical procedure. We do not believe that Medicare's exclusion of specific services from the definition of ''radiology and certain other imaging services'' for purposes of the physician self-referral prohibition should result in such services being considered ''surgical services'' for purposes of the revised ASC payment system.

Further, as we explain above, we believe that the characterization of procedures as surgery for purposes of their performance in ASCs is best left to the expertise of the CPT Editorial Panel. We do not believe that services designated as radiology services by the CPT Editorial Panel are appropriately classified as covered surgical procedures in ASCs, facilities that specialize in the delivery of ambulatory surgical services. However, as discussed further in section IV.C.2. of this final rule, we do believe that it is appropriate to provide separate ASC payment for certain ancillary services that are integral to the covered surgical procedures. Thus, we will provide separate payment to ASCs under the revised payment system for radiology services that are integral to the performance of an ASC covered surgical procedure when that radiology procedure is one of those for which separate payment is made under the OPPS. That is, separate payment will be made for covered ancillary radiology services integral to covered surgical procedures that are provided in the ASC immediately before, during, or immediately following the surgical procedure.

After consideration of the public comments we received, we are finalizing our proposal to define surgery as those procedures described by CPT codes within the surgical range of 10000 through 69999, without modification. In addition, we are including within our definition of a covered surgical procedure payable in the ASC setting those Level II HCPCS codes or Category III CPT codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range that we have determined do not pose a significant safety risk, that we would not expect to require an overnight stay when performed in ASCs, and that are separately paid under the OPPS. An illustrative list of covered surgical procedures under the revised ASC payment system, including Category I and Category III CPT codes and Level II HCPCS codes, can be found in Addendum AA to this final rule. An illustrative list of radiology services and other covered ancillary services that are eligible for separate ASC payment when provided integral to an ASC covered surgical procedure on the same day is located in Addendum BB to this final rule.

2. Procedures Excluded From Payment Under the Revised ASC Payment System

As stated above, in the August 2006 proposed rule for the revised ASC payment system, we proposed to allow payment to ASCs for all procedures described by CPT codes within the surgical range of 10000 through 69999, or by Level II HCPCS codes or Category III CPT codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range, that do not pose a significant safety risk to Medicare beneficiaries and that are not expected to require an overnight stay. Having established what we consider to be 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 we expect would require an overnight stay within the bounds of prevailing medical practice. We discuss in the next section how we proposed to identify procedures that could pose a significant safety risk.

a. Significant Safety Risk

First, we proposed to exclude from ASC payment any procedure that is included on the current OPPS inpatient list, that is, those procedures designated as requiring inpatient care under § 419.22(n). (See Addendum E to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68385 through 68398).) The procedures included on that list are typically performed in the hospital inpatient 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 believed that any procedure for which we did not allow payment in the hospital outpatient setting due to safety concerns would not be safe to perform in an ASC.

Second, we proposed to exclude from ASC payment procedures that the CY 2005 Part B Extract Summary System (BESS) data indicated were performed 80 percent or more of the time in the hospital inpatient setting, even if those procedures were not included on the OPPS inpatient list. We selected an 80-percent threshold because we believed that an 80-percent level of inpatient performance was a fair indicator that a procedure is most appropriately performed on an inpatient basis and, as such, would pose a significant safety risk for Medicare beneficiaries if performed in an ASC. We believed that procedures with inpatient utilization frequencies above the proposed threshold were complex and were likely to require a longer and more intensive level of care postoperatively than what is provided in a typical ASC. We also believed 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 proposed to retain some of the specific criteria for evaluating safety risks that are listed in § 416.65(b)(3) of our existing regulations. Procedures that involve major blood vessels, major or prolonged 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 proposed to exclude from ASC payment surgical procedures that may be expected to involve any of these characteristics, based on evaluation by our medical advisors. We noted that most of the procedures that our medical advisors identified as involving any of the characteristics listed in § 416.65(b)(3) also require overnight or

inpatient stays, reinforcing our belief that they should be excluded from ASC payment.

Finally, we proposed not to continue applying under the proposed revised system the current time-based, prescriptive criteria at §§ 416.65(b)(1) and (b)(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 believed these criteria were no longer clinically appropriate for purposes of defining a significant safety risk for surgical procedures.

We indicated that, in light of the proposed changes for evaluating procedures to identify those that pose a significant safety risk for beneficiaries when performed in ASCs, we believed 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 believed 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 did not seem relevant within the context of the proposal only to exclude from ASC payment under the revised payment system those surgical procedures that pose a safety risk or are expected to require an overnight stay. We would expect the types of surgical 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 stay.

We proposed to add new Subpart F to 42 CFR Part 416 to reflect coverage, scope, and payment for ASC services under the revised payment system. Included in the changes would be new § 416.166 to reflect the changes that we proposed 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 surgical procedures beginning January 1, 2008. To set the provisions that are applicable to our existing ASC payment system apart from those that would apply to the revised ASC payment system, as we proposed, in the CY 2007 OPPS/ASC final rule with comment period, we revised the section headings of Subparts D and E of Part 416 to clearly denote the provisions that govern covered surgical procedures furnished before January 1, 2008. We also added §§ 416.76 and 416.121 to clearly denote the effective dates of Subparts D and E (71 FR 68226).

Comment: Commenters provided many recommendations regarding the proposed criteria for evaluating which procedures should be excluded from the ASC list of covered surgical procedures that varied greatly. At one end of the spectrum, some commenters recommended that CMS only exclude from ASC payment those procedures that are included on the ''inpatient list'' used under the OPPS. They believed that all procedures not on the OPPS inpatient list are safe for performance in ASCs and that, by the specification of their payable status under the OPPS, they do not require an overnight stay.

Some commenters suggested that CMS create the ASC exclusionary list by individually reviewing surgical procedures based upon data that demonstrate the risks, complications, and overall safety of a given procedure, rather than attempting to specifically apply the standards of the proposed criteria. They believed that health outcomes databases, including the National Surgical Quality Improvement Project and patient and device registries, could provide further information to refine an initial safety assessment based on the proposed criteria when certain procedures were identified as needing further consideration and evaluation. The commenters recommended this flexible and specific approach to allow for full consideration of the surgical aspects of each procedure, in order to make an appropriate determination regarding its safety for ASC performance. The commenters believed CMS could work with surgical professional associations and external surgical experts to facilitate a smooth and efficient clinical review process.

In contrast, other commenters recommended that CMS implement more stringent review criteria than our criteria under the existing payment system for evaluating which procedures are unsafe for performance in ASCs. They believed that beneficiary safety could be better protected if CMS would adopt review criteria that would exclude more procedures from ASC performance than those criteria currently in place, while maintaining the existing limitations on operating and recovery room times.

Response: We believe that both ends of the spectrum of public comments are inconsistent with our goal of only excluding those procedures from ASC payment that are unsafe for performance in ASCs or are expected to require an overnight stay. We agree with the perspective of most commenters that procedures on the OPPS inpatient list should also be excluded from ASC payment. However, while we strongly disagree with the contention by some commenters that all procedures performed in HOPDs are appropriate for performance in ASCs, we also believe that instituting criteria that are more restrictive than those currently in place would be inappropriate, because we do not have safety concerns regarding procedures that are already included on the ASC list of covered surgical procedures.

Typically, HOPDs are able to provide much higher acuity care than ASCs. ASCs have neither patient safety standards consistent with those in place for hospitals, nor are they required to have the trained staff and equipment needed to provide the breadth and intensity of care that hospitals are required to maintain. According to current CMS standards, hospitals must meet numerous documentation, infection prevention, and patient assessment requirements that are not applied to ASCs. Therefore, there are some procedures that we believe may be appropriately provided in the HOPD setting that are unsafe for performance in ASCs. Thus, we are not adopting a final policy to exclude only those surgical procedures on the OPPS inpatient list from ASC payment under the revised payment system.

Nonetheless, as stated in our August 2006 proposal and consistent with MedPAC recommendations, we are committed to revising the ASC list of covered surgical procedures so that it excludes only those surgical procedures that pose significant safety risks to beneficiaries or that are expected to require an overnight stay. We believe that adoption of a policy similar to that recommended by MedPAC would serve both to protect beneficiary safety and increase beneficiary access to surgical procedures in appropriate clinical settings. We also believe that this approach is most consistent with the PPAC's recommendation that we provide payment under the revised ASC payment system for all safe and appropriate services. Thus, we do not believe that it would be appropriate to implement more restrictive criteria for evaluating procedures for exclusion from ASC payment or even to maintain all of the current criteria that we use under the existing payment system to evaluate the appropriateness of including procedures on the ASC list. We continue to believe the current limitations on operating room and recovery room times for ASC procedures

are no longer clinically relevant to assessing the safety risk of surgical procedures. Our comprehensive review of all surgical procedures has convinced us that there are procedures in addition to those included on the CY 2007 ASC list of covered surgical procedures that may be safely performed in ASCs, and that increasing the number and types of procedures for which Medicare provides ASC payment is appropriate.

Regarding our proposed overall approach to evaluating procedures for exclusion from the ASC list of covered surgical procedures, we believe that our evaluation process is generally consistent with the approach advised by some commenters that we apply the proposed criteria as part of an initial safety assessment, and then conduct procedure-specific analyses of possible risks and complications of individual procedures based on available data. In preparing the proposal for the revised ASC payment system, we reviewed each surgical procedure that is separately payable under the OPPS and not already on the CY 2007 ASC list and with inpatient utilization of less than 80 percent against the proposed safety and overnight stay criteria and identified a subset of procedures for further assessment if we had concerns about their potential safety risk. We then used all of the information available to us to arrive at a preliminary determination regarding each procedure's suitability for payment in the ASC setting. These preliminary determinations constituted our proposed treatment of the procedures under the revised ASC payment system, and the status of the codes was open to public comment in the August 2006 proposed rule. We received detailed information and recommendations from many commenters, including hospitals, ASCs, device manufacturers, and physician specialty organizations, as well as physician experts, regarding the proposed treatment of many surgical procedure codes. Summaries of these comments and our responses follow later in this section of this final rule.

Comment: A number of commenters expressed concerns about the safety implications of a greatly expanded list of surgical procedures to be performed in ASCs. They advocated implementation of specific additional measures for tightening and strengthening the criteria we proposed to use to evaluate the potential for beneficiary risk associated with surgical procedures. Included in the commenters' numerous recommendations were the following comments:

(1) Make no changes to the current criteria until the ASC Conditions for Coverage are revised to ensure that patient protections comparable to those in place in hospitals are in place in ASCs.

(2) Apply the existing and proposed criterion to exclude procedures from the ASC list that involve major blood vessels, by adopting a specific list of blood vessels that CMS defines as major blood vessels, in order to provide more certainty about which procedures would be excluded. Some commenters recommended that CMS adopt the definition of a major blood vessel advanced in a medical textbook, *Essentials of Anatomy & Physiology,* 6th Edition, by Seeley, Stephens and Tate. For procedures that involve blood vessels defined by Seeley, et al., as major, but that are already being performed safely in ASCs (for example, CPT code 36870, Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)), the commenters suggested that CMS retain them as ASC covered surgical procedures, thereby allowing their continued payment when performed in ASCs.

(3) Apply the existing and proposed criterion to exclude from ASC payment those procedures requiring major or prolonged invasion of body cavities, by defining ''prolonged'' invasion as referring to any procedure in which the patient is under anesthesia for 90 minutes or longer, and expand the definition of body cavity to include major blood vessels.

(4) Exclude from ASC payment procedures that commonly require systemic thrombolytic therapy. Some commenters recommended that CMS exclude procedures that involve blood vessels that, if occluded, would require inpatient lytic therapy, while other commenters recommended more generally that CMS exclude procedures that may result in a patient's need for lytic therapy. Lytic or inpatient thrombolytic therapy as used in this context both refer to systemic thrombolytic therapy.

(5) Disallow procedures that require puncturing of the femoral vessels for access. Some commenters recommended that this exclusion be for procedures accessing either the femoral artery or the femoral vein, while other commenters would have limited the exclusion to only those procedures requiring femoral arterial access.

(6) Implement a quantitative measure (greater than or equal to 15 percent of total blood volume) to define the existing and proposed criterion to exclude from the list procedures that generally result in extensive blood loss.

(7) Use a 50-percent inpatient threshold for excluding procedures from the ASC list instead of the proposed 80-percent threshold. While some commenters recommended lowering the proposed threshold for exclusion of procedures from the ASC list from 80 percent to 50 percent, several other commenters suggested that CMS should not apply a specific numerical threshold of inpatient utilization at all to its evaluation of procedure safety. They noted that this could have the unintended effect of automatically excluding some procedures from ASC payment simply because of limited data indicating their performance slightly more than 80 percent of the time in the inpatient setting, while data for clinically similar codes reflected inpatient performance slightly less than the 80-percent threshold. Instead, these commenters recommended that we evaluate each surgical procedure with respect to the other proposed criteria, based on the clinical characteristics of the procedure itself. The group of commenters recommending establishment of a lower threshold of 50 percent believed that this modified standard would better enable us to identify procedures that are typically clinically complex and have a higher risk of complications and extensive postoperative care. They suggested that setting the threshold at 50 percent would ensure that procedures performed the majority of time in the inpatient setting would be excluded from ASC payment.

(8) Require that patients be assessed for comorbidities and anesthesia risk using the American Society of Anesthesiologists' tool, and those patients who are high risk, such as patients over age 85 or with morbid obesity, should be required to go to hospital settings for surgical procedures.

(9) Identify and implement outcome and process measures to assess aspects of quality across care settings, including ASCs. To develop those measures, some commenters suggested that CMS work closely with the Hospital Quality Alliance (HQA) and the Ambulatory Quality Alliance (AQA) (formerly both organizations were known as the AQA). The HQA has already begun to include the measures of care used in the Surgical Care Improvement Project, and some commenters believed that the goal of preventing complications in the care of surgical patients provides an appropriate starting point for determining the correct measures for assessing important aspects of the safety

and quality of all types of ambulatory surgery.

Response: We appreciate the commenters' concerns regarding beneficiary safety and gave consideration to each of the individual recommendations listed above. We respond to each of these individually as follows:

(1) *Maintain the current procedure review criteria until after the ASC Conditions for Coverage are revised.*

We do not believe that postponing revisions to our review criteria until after the ASC Conditions for Coverage are revised is warranted. We cannot predict when those revisions will be issued, and we are confident that the criteria we will use to evaluate procedures for exclusion from the list of covered surgical procedures under the revised ASC payment system are appropriate and serve to protect beneficiary safety in the current environment.

(2) *Specifically adopt a defined list of ''major blood vessels.''*

As we stated earlier, we believe it is important to maintain flexibility in our review of procedures for safe performance in the ASC setting, consistent with our past practice regarding this criterion. As noted by commenters requesting a specific definition of this criterion, there are some procedures already on the ASC list that are being safely performed in ASCs and that involve vessels that would be defined as major according to the recommendations of some commenters. We do not agree with these commenters that it would be logical or clinically consistent for us to adopt a specific definition of major blood vessels to evaluate procedures for exclusion from ASC payment, yet still continue to provide ASC payment for procedures that would otherwise be excluded, except for their history of safe performance in ASCs. We believe the involvement of major blood vessels is best considered in the context of the clinical characteristics of individual procedures, as recommended by other commenters, and see no need to adopt a defined list of major blood vessels.

(3) *Define prolonged invasion of a body cavity as any procedure in which the patient is under anesthesia for 90 minutes or longer, and expand the definition of body cavity to include major blood vessels.*

We do not believe that considering major blood vessels to be included in the definition of a body cavity is clinically sensible, based on the general medical understanding of the terms. In addition, we already have a separate safety review criterion regarding major blood vessels, and we believe that evaluation of the safety of procedures involving major blood vessels will continue to be appropriately assessed using that criterion. We also do not believe that prolonged invasion should be defined as anesthesia for 90 minutes or longer. There are surgical procedures that require more than 90 minutes that do not invade a major body cavity at all, and maintaining that time-based restriction would be contrary to the recommendations of MedPAC and current clinical practice. We believe the criterion regarding major or prolonged invasion of body cavities is most appropriately evaluated through a flexible review approach, consistent with our past practice, in which we consider the criterion and its relationship to each specific surgical procedure. Therefore, we are not expanding the current criterion regarding invasion of a body cavity to include the length of time the beneficiary will be under anesthesia or to incorporate major blood vessels.

(4) *Exclude from ASC payment procedures that commonly require systemic thrombolytic therapy.*

We agree with the commenters that systemic thrombolytic therapy is unsafe for performance in ASCs. Systemic thrombolytic therapy involves significant clinical risks and is not an appropriate procedure for initiation in ASCs if its use is anticipated. We have historically considered in our clinical evaluation of the safety of procedures for performance in ASCs the likely need for systemic thrombolytic therapy in association with a surgical procedure, but we have never previously made that an explicit safety review criterion. We agree with the commenters that it should be a specific criterion for evaluation of procedure safety. Therefore, we are making it explicit that the final criteria used to evaluate the safety of procedures for performance in ASCs at § 416.166(c)(5) include the criterion that covered surgical procedures may not be of a type where systemic thrombolytic therapy would commonly be required.

(5) *Exclude procedures that require use of the femoral vessels for access.*

We do not agree with some commenters' position that excluding all procedures that involve the femoral vessels is reasonable or necessary to ensure the patient safety of surgical procedures performed in ASCs. Other commenters stated that there are instances in which the performance of procedures may require use of femoral vessels due to the beneficiary's particular physical condition. For example, a beneficiary who has experienced prolonged exposure to vascular sclerosing agents (such as chemotherapy) or has been on hemodialysis for many years may not have upper body peripheral blood vessels that are adequate even to support the basic intravenous access required during any surgical procedure performed under general anesthesia. In such a case, the surgeon may need to use the femoral vein just to provide routine intravenous access during surgery. In other cases, the use of the femoral vessels may be required for certain surgical procedures. For instance, the femoral blood vessels may be accessed to create an arteriovenous fistula for hemodialysis using a graft, as described by CPT code 36825 (Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft) or CPT code 36830 (Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (e.g., biological collagen, thermoplastic graft)). Both of these procedures that may directly involve the femoral vessels have been on the list of covered ASC procedures since before July 2000, and we have no concerns about their safe performance in ASCs. We do not believe that it makes clinical sense to prohibit use of the femoral vessels in ASC procedures, knowing that they may be needed in any number of situations and that femoral access has been safely achieved in ASCs for years. We believe that our process for clinical review of individual procedures, during which our medical advisors consider the specific performance characteristics of a particular surgical procedure, is the most appropriate method for ensuring that procedures that pose a significant safety risk are excluded from ASC payment. As evidenced by the history of safe performance in ASCs of some procedures that utilize femoral access, we agree with the commenters who believe that it is the specific surgical procedure, rather than the method of vascular access, that must be fully evaluated to assess a procedure's safety in ASCs.

(6) *Adopt a quantitative definition of ''extensive blood loss.''*

We do not believe that the recommendation by some commenters that we revise the criteria used to evaluate procedures for exclusion from the ASC list by quantifying extensive blood loss is necessary or advisable. The existing and proposed criterion related to blood loss requires exclusion of procedures that ''generally result in extensive blood loss'' (42 CFR 416.65(b)(3)(i) and 42 CFR 416.166(c)(1),

respectively), and we have historically evaluated this criterion in considering surgical procedures for ASC payment. We do not believe that identifying a specific amount of blood loss that is considered by some to be ''extensive'' would improve our clinical review regarding procedural safety. For most surgical procedures, specific estimates of expected blood loss are not available, and we do not believe that a discussion of whether or not a procedure generally results in a loss of 14 percent versus 16 percent of a beneficiary's blood volume would be clinically meaningful and contribute to our ability to evaluate a surgical procedure's potential for safe performance in ASCs.

(7) *Adopt a 50-percent inpatient utilization threshold for exclusion of procedures from the ASC list.*

We reexamined our proposal to exclude all procedures from ASC payment that are performed in the inpatient setting 80 percent or more of the time. Although the recommendations of some commenters advocated using a lower threshold to exclude more procedures from ASC payment, we confirmed that using any relatively arbitrary threshold resulted in unintended inconsistencies in the treatment of clinically similar procedures. There were several instances in which one procedure in a clinical family would be excluded from ASC payment based on its inpatient utilization of just slightly over 80 percent, whereas our clinical review of other members of the family indicated that those procedures were safe for performance in ASCs, with inpatient utilization of slightly less than 80 percent. For example, we proposed to exclude CPT codes 33207 (Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular) and 33208 (Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular) from ASC payment under the revised payment system because the inpatient utilization for those procedures was higher than 80 percent and, therefore, we did not specifically review the procedures to assess their clinical safety or need for an overnight stay before proposing to exclude them. We did not propose to exclude CPT code 33206 (Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial), the other procedure in the same family of codes as CPT codes 33207 and 33208, because the inpatient utilization for that procedure was somewhat lower than 80 percent, and our clinical review, based on the other safety and overnight stay criteria proposed for the revised ASC payment system, led to our belief that it was appropriate for performance in ASCs. When we performed a clinical review of CPT codes 33207 and 33208 in order to respond to public comments, we determined that CPT codes 33207 and 33208 do not pose a significant risk to beneficiary safety and are not expected to require an overnight stay, so they are appropriate for performance in ASCs, along with CPT code 33206. Therefore, we have removed both CPT codes 33207 and 33208 from the list of excluded procedures for the revised ASC payment system. We are also, as proposed, not excluding CPT code 33206 from eligibility for ASC payment. This more flexible approach, without application of a specific inpatient utilization threshold, allows us to treat the individual members of the same family of procedures consistently as a clinically coherent group, while considering them in the context of our final safety and overnight stay criteria for the revised ASC payment system.

We also identified a number of surgical procedures with high Medicare inpatient utilization because, most of the time, the procedures are performed with other surgical procedures for beneficiaries who are hospital inpatients. Thus, although the data reflect high inpatient utilization, the procedures themselves are not unsafe for ASC performance, nor do they typically require an overnight stay. Specifically, commenters argued that the high inpatient utilization of CPT code 64447 (Injection, anesthetic agent; femoral nerve, single) was due to its frequent use during inpatient surgical procedures, whereas the injection may also be performed safely in ASCs on its own as an ambulatory pain management intervention. They believed that using the inpatient utilization as the basis for the exclusion of this procedure from ASC payment was unfair because we should evaluate the procedure itself specifically based upon its clinical characteristics, rather than based upon utilization data which could be misleading with respect to the procedure's potential for safe performance in the ASC setting. Our clinical review of CPT code 64447, in response to comments, convinced us that it would clearly not pose a significant safety risk or be expected to require an overnight stay when performed in ASCs and should not be excluded from the list of covered surgical procedures under the revised ASC payment system.

Therefore, we concluded that, in the cases of CPT codes 33207, 33208, and 64447, the utilization data alone could not be relied upon to support a decision to exclude these procedures from ASC payment and, as evidenced by our proposed list of excluded procedures, there were many procedures paid under the OPPS that were not performed more than 80 percent of the time on an inpatient basis but that were proposed for exclusion from ASC payment because of their safety risk or expected need for an overnight stay. Therefore, for this final rule, we evaluated each of the procedures that we had proposed for exclusion from ASC payment based on inpatient utilization of 80 percent or more and made separate determinations about the safety and need for an overnight stay for each of those procedures using all available information, as we did for all other procedures in the surgical range of the CPT code set.

Thus, while we proposed an 80-percent inpatient utilization threshold as one criterion for excluding surgical procedures from ASC payment, we now believe that we will reach more appropriate, clinically consistent decisions regarding procedures for exclusion from ASC payment by not adopting any specific numerical threshold for inpatient utilization that would automatically exclude surgical procedures from ASC payment. Rather than institute a definite threshold for inpatient utilization, we will examine all the clinical information regarding a surgical procedure, including its inpatient utilization, to determine whether or not a procedure would pose a significant risk to beneficiary safety or would be expected to require an overnight stay if performed in an ASC. We will not make final our proposal to exclude procedures from the ASC list of covered surgical procedures based solely on their inpatient utilization of 80 percent or more.

(8) *Require beneficiary assessment of individual surgical risk and do not permit high risk patients to receive ASC services.*

We do not believe that it would be appropriate to accept the commenters' recommendation that patients with certain specified demographic characteristics or comorbidities be automatically excluded from being considered for surgery within an ASC. The recommendation would require ASCs to deny services to individual beneficiaries who are found, based on an appraisal through a specific assessment tool, to have a high level of risk. Section 416.2 defines an ASC as providing surgical services to patients not requiring hospitalization. Thus, ASCs must ensure that each patient is assessed for relevant risk factors by the physician prior to performing the

surgical procedure, in order to screen out patients who are likely to require hospitalization in connection with the planned procedure. We require physicians to make these assessments as a part of their decisions regarding where to perform a surgical procedure for specific Medicare beneficiaries, prior to referring them to facilities for those surgical procedures. The ASC Conditions for Coverage specifically state in § 416.42(a) that ''a physician must examine the patient immediately before surgery to evaluate the risk of anesthesia and of the procedure to be performed.'' In addition, we protect Medicare beneficiary safety through our process of excluding procedures from ASC payment that pose a significant safety risk for the typical Medicare patient. In summary, we do not believe that it is necessary or appropriate for CMS to mandate that ASCs use a specific assessment tool in conducting these required beneficiary assessments.

(9) *Identify and implement outcome and process measures in ASCs to assess quality of care.*

We will take into consideration for future action the recommendation by some commenters that we identify and implement outcome and process measures to assess aspects of quality of care across settings, including ASCs, taking into consideration our final policy for the CY 2009 OPPS that will require hospitals to meet quality reporting standards to receive the full OPPS update (71 FR 68189). We agree that this could be an appropriate next step and is consistent with CMS'' policies being implemented in other beneficiary care settings. In fact, section 109(b) of the Medicare Improvements and Extension Act under Division B of the Tax Relief and Health Care Act of 2006, Public Law 109–432, enacted on December 20, 2006, specifies that the Secretary may require that in order to receive the full annual payment update, ASCs must report data on selected measures of quality. The provisions for ASC services are to apply in a manner similar to which they apply to hospital outpatient services, effective January 1, 2009.

After considering the public comments received, we are finalizing our proposal, with modification, to exclude from ASC payment all surgical procedures that could pose a significant safety risk to Medicare beneficiaries or are expected to require an overnight stay. The criteria to be used to identify procedures that could pose a significant safety risk when performed in an ASC include those surgical procedures that: generally result in extensive blood loss; require major or prolonged invasion of body cavities; directly involve major blood vessels; are emergent or life-threatening in nature; commonly require systemic thrombolytic therapy; are designated as requiring inpatient care under § 419.22(n); can only be reported using a CPT unlisted surgical procedure code (see section III.B. of this final rule for further discussion); or are otherwise excluded under § 411.15. We are not adopting the specific 80-percent inpatient utilization threshold that we proposed for exclusion of surgical procedures from ASC payment. The final revised policy regarding covered surgical procedures is set forth in § 416.166 of this final rule, effective January 1, 2008.

b. Overnight Stay

A longstanding criterion for determining which procedures are appropriate for inclusion on the ASC list of covered surgical procedures 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 postoperative recovery room or short-term (not overnight) convalescent room.'' Under § 416.65(b)(1)(ii), we have historically considered procedures that require more than 4 hours of recovery or convalescent time to be inappropriately performed in the ASC.

We have heard many differing opinions of what constitutes an ''overnight'' stay, ranging from ''more than 24 hours'' to time spent in recovery after sunset. After deliberation and consideration of several options, in the August 2006 proposed rule for the revised ASC payment system, we proposed to exclude from ASC payment any procedure for which prevailing medical practice dictates that the beneficiary would typically be expected to require active medical monitoring and care at midnight following the procedure (hereinafter ''overnight stay''). During the development of the August 2006 proposed rule, our clinical staff evaluated each surgical procedure using available claims and physician pricing data, as well as their 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 proposed 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 services for which Medicare makes payment. The expectation is that surgical procedures performed in 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 defining measure of ''overnight stay.'' We proposed to add the requirement that procedures will typically not be expected to require active medical monitoring and care at midnight following the procedure to proposed new § 416.166(c)(5).

Comment: Some commenters recommended that CMS use ''less than 24 hours'' as the definition of an overnight stay. Several of the commenters stated that the same 24-hour postoperative recovery standard that applies in HOPDs should apply in ASCs. One commenter stated that CMS' definition of overnight stay related to survey and certification for ASCs is a planned stay of over 24 hours and, that conversely, when the ''length of stay is less than 24 hours, it is not considered an overnight stay.'' Further, several commenters noted that a number of States allow ASCs to perform procedures that require stays of up to 23 or 24 hours.

One commenter group argued that the terms ''ambulatory'' and ''outpatient'' surgery describe the same kind of care, and that the same 24-hour postoperative recovery standard should apply in both ASC and HOPD settings. Some commenters suggested that, if CMS allowed all procedures that are performed in HOPDs to be performed in ASCs, no specific definition of overnight stay would be required because any procedure paid under the OPPS would be presumed to require no overnight stay and that the same assumption should be applied to ASCs.

A number of other commenters agreed with our proposal that procedures requiring an overnight stay should not be performed in an ASC and specifically endorsed our definition of overnight stay. They also believed that the proposed definition is consistent with other accepted definitions and standards of the term.

Several commenters believed that our proposal, if adopted, would require ASCs performing and billing covered surgical procedures to transfer patients to other facilities if the recovery of

individual patients extended beyond midnight on the day of the procedure, in order to receive payment under the revised ASC payment system. Other commenters expressed concern that procedures performed later in the day in ASCs would be treated differently for purposes of ASC payment than those procedures that were performed in the morning, in terms of allowing for adequate recovery time.

Response: We want to clarify our proposal to use the expected need for medical monitoring at midnight following the performance of a procedure as a consideration in determining whether a surgical procedure should be excluded from ASC payment. Our proposal does not affect the distinct care ASCs may provide in individual cases at various times of the day, nor does it alter the ASC payment for covered surgical procedures and covered ancillary services. As we explained in the August 2006 proposed rule, we proposed to exclude surgical procedures from ASC payment only based on their expected need for an overnight stay or the risk they pose to beneficiary safety. We identified the need for medical monitoring at midnight as a clinical measure that was meaningful to our clinical staff and advisors in their assessment, on a procedure-by-procedure basis, of the expected postoperative needs of the typical Medicare beneficiary, in order to determine whether a procedure was likely to require an overnight stay.

We agree with some commenters that the criteria currently in place under the existing ASC payment system that limit covered surgical services to those that do not generally exceed a total of 90 minutes operating time and a total of 4 hours of recovery or convalescent time are both outdated and inconsistent with the proposed policy to base exclusion on the need for an overnight stay. We also agree with the commenters who recognized that the proposed revised measure to facilitate identification of those procedures requiring an overnight stay is considerably less restrictive than the current criteria and, at the same time, the use of midnight as a reference point is clinically meaningful and adequate to ensure beneficiary safety.

As stated above, a beneficiary'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, as defined at § 416.2, ASC means ''any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.'' Thus, ASCs are not certified by Medicare to provide overnight care, and there is longstanding policy to exclude from coverage in ASCs those surgical procedures that require overnight stays, as evidenced by our existing criterion at § 416.65(b)(1)(ii) that requires CMS to limit covered surgical procedures to those that do not generally exceed a total of 4 hours of recovery time following surgery. The expectation is that a beneficiary undergoing a procedure in an ASC will recover from anesthesia and return home on the same day that he or she reported to the ASC for a scheduled procedure. This expectation is inconsistent with a 24-hour postoperative recovery period as recommended by some commenters.

The commenters' comparisons of ASCs to HOPDs are not persuasive for many reasons. Most importantly among these is the fact that HOPDs, unlike ASCs, have medical and nursing staff on duty 24 hours a day and all of the resources of the hospital to support the care requirements of beneficiaries in that setting.

After consideration of the public comments we received, we continue to believe that it is appropriate to exclude from ASC payment any procedure for which standard medical practice dictates that the beneficiary would typically be expected to require active medical monitoring and care at midnight following the procedure. Therefore, we are finalizing, with editorial modification to include this requirement in the general standards for covered surgical procedures at § 416.166(b), our proposal to exclude these surgical procedures from ASC payment.

B. Treatment of Unlisted Procedure Codes and Procedures That Are Not Paid Separately Under the OPPS

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 covered surgical 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 procedures reported by unlisted CPT codes is made only at the discretion of the contractor under the MPFS.

Because of concerns about the potential for safety risks when procedures that may only be reported with unlisted procedure CPT codes are performed, in the August 2006 proposed rule for the revised ASC payment system, we proposed to continue excluding CPT unlisted surgical procedure codes from ASC payment. 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, major or prolonged invasion of body cavities, or extensive blood loss, or was emergent or life-threatening in nature.

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 whose payments are packaged under the OPPS. Packaged CPT codes under the OPPS are identified by status indicator ''N'' in Addendum B of the CY 2007 OPPS/ASC final rule with comment period (71 FR 68283 through 68384), and their OPPS payment is provided through payment for other separately payable services. We made this proposal for two reasons. First, we would not be able to establish an ASC payment rate for packaged surgical procedures using the same method we proposed 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, ASCs, just like hospitals, would receive payment for these packaged surgical procedures because their costs would already be included in the APC relative payment weights upon which the ASC payment rates would be based.

Comment: A few commenters recommended that CMS not exclude all unlisted CPT codes from ASC payment as proposed. Some commenters believed that, because Medicare makes facility payments for unlisted CPT codes under the OPPS, CMS should provide the same treatment in ASCs. Other commenters suggested that, for groups of related CPT codes in which all codes but the related unlisted code are provided payment in ASCs, CMS should also include the unlisted code on the ASC list of covered surgical procedures. For example, all of the specific CPT codes in the surgical hysteroscopy

subsection of CPT (CPT codes 58558 through 58578) are currently on the ASC list. One commenter contended that because CMS had already determined that all of those specific hysteroscopy procedures are safe for performance in ASCs, the related unlisted hysteroscopy procedure (CPT code 58579, Unlisted hysteroscopy procedure, uterus) should also be deemed to pose no significant safety risk or require an overnight stay.

Response: We appreciate the commenters' examples of unlisted codes in families where all of the other procedures in the CPT subsection are not excluded from ASC payment, in support of their recommendation that the related unlisted procedure code should be treated comparably. However, the fact remains that we do not know what specific procedure would be represented by an unlisted code. Our charge requires us to evaluate each surgical procedure for potential safety risk and the expected need for overnight monitoring and to exclude such procedures from ASC payment. It is not possible to evaluate procedures that would be reported by unlisted CPT codes according to these criteria.

We continue to believe that because our final policy under the revised ASC payment system excludes from ASC payment those procedures that pose a significant safety risk in ASCs or would be expected to require an overnight stay, it would not be appropriate to provide ASC payment for unlisted CPT codes in the surgical range, even if payment may be provided under the OPPS. As discussed earlier, ASCs do not possess the breadth and intensity of services that hospitals must maintain to care for patients of higher acuity, and we would have no way of knowing what specific procedures reported by unlisted CPT codes were provided to patients, in order to ensure that they are safe for ASC performance. Therefore, we are finalizing in § 416.166(c)(7) our proposal, without modification, to exclude from ASC payment under the revised ASC payment system all procedures reported by unlisted surgical procedure codes.

Comment: A few commenters expressed concern that payments for certain surgical services that are packaged under the OPPS are frequently paid through the OPPS payments for more comprehensive services that we had proposed to define as nonsurgical because they are not classified by CPT within the surgical range of codes. Therefore, these packaged surgical services would not be paid under the revised ASC payment system. They pointed out that when ASCs perform these packaged surgical services as part of providing a more comprehensive nonsurgical service, the ASC would receive no payment for the surgical service. To illustrate the problem, commenters provided examples of the surgical codes that typically receive packaged payment under the OPPS through payment for radiology services. The minor packaged surgical procedures included numerous injection and catheter placement procedures in the surgical range of CPT codes that generally accompany radiology services for purposes of injecting contrast or facilitating another nonsurgical intervention. These commenters recommended that CMS expand the definition of surgical procedures to include invasive radiology services that have a surgical component, including those radiology procedures that are performed in association with a surgical procedure proposed for packaged payment under the revised ASC payment system, to enable ASCs to receive payment for the comprehensive service, including both the radiology service and the minor surgical procedure. Alternatively, several other commenters supported our proposal to package payment under the revised ASC payment system for the minor surgical procedures for which payment is also packaged under the OPPS, rather than paying for them separately.

Response: We continue to believe that packaging payment for those surgical services that are packaged under the OPPS is appropriate under the revised ASC payment system. This policy is aligned with the recommendation of the PPAC to apply payment policies uniformly in the ASC and HOPD settings. It also maintains comparable payment bundles under the OPPS and the revised ASC payment system for these services, consistent with the recommendation of MedPAC to maintain consistent payment bundles under both payment systems.

Packaged surgical services are minor procedures and are usually reported with a more comprehensive procedure that may itself be nonsurgical and, therefore, excluded from payment under the revised ASC payment system. See section III.A.1. of this final rule for a further discussion of the definition of surgical procedure under the revised ASC payment system. We believe that payment for these minor surgical procedures would be appropriately packaged into payment for comprehensive surgical procedures that are separately paid in the ASC setting, when those minor surgical procedures are provided in support of the comprehensive surgical procedures. In the circumstances referred to by the commenters, the minor surgical procedures are performed in support of comprehensive nonsurgical services and payment for the minor surgical procedures is packaged into payment for the nonsurgical services under the OPPS. Although the packaged procedures are surgical according to our definition for the revised ASC payment system, we do not believe it is reasonable or appropriate to assign a different packaging status for these procedures under the revised ASC payment system than is assigned under the OPPS. The minor surgical procedures are not separately paid in the OPPS and, thus, are not eligible for separate payment under the revised ASC payment system. In addition, if the procedures are only performed in conjunction with major services not payable in ASCs, Medicare also will make no packaged payment for these minor surgical procedures. As we discuss further in section III.A. of this final rule, Medicare pays ASCs for the performance of ambulatory surgical procedures, not for providing nonsurgical services. We do not agree that we should define surgical procedures under the revised ASC payment system to include other types of services, such as radiology services, just because they are provided in association with a minor surgical procedure in the CPT surgical range of codes. Instead, we continue to believe that the other types of services, including radiology services, are not appropriate for performance in ASCs unless they are integral to covered surgical procedures. We see no rationale for considering comprehensive radiology services to be integral to the minor surgical procedures.

After considering all public comments received, we are finalizing, without modification, our proposal to provide packaged payment under the revised ASC payment system for all surgical procedures packaged under the OPPS for the same calendar year. Therefore, we will exclude these surgical procedures from separate payment in the ASC setting under the revised payment system, and they will not be included on the ASC list of covered surgical procedures. We believe that this approach will provide appropriate packaged payment for minor surgical procedures provided in association with significant ASC covered surgical procedures. When these minor surgical procedures are performed in support of comprehensive nonsurgical procedures, they are not appropriate for ASC payment because the more comprehensive service is not a surgical

procedure paid under the revised ASC payment system. HCPCS codes for surgical procedures for which payment will be packaged under the revised ASC payment system are identified in Addendum AA to this final rule with payment indicator ''N1'' (Packaged service/item; no separate payment made).

C. Treatment of Office-Based Procedures

According to the general standard in § 416.65(a)(2) of the existing regulations, procedures that ''are commonly performed, or that may be safely performed, in physicians' offices'' are excluded from the ASC list of covered surgical procedures. We did not propose to continue to apply this provision under the revised ASC payment system. Rather, in the August 2006 proposed rule for the revised ASC payment system, we proposed to allow ASC payment for surgical procedures that are commonly and safely performed in the office setting. We reasoned that the types of procedures performed in physicians' offices would neither pose a significant safety risk nor require an overnight stay when performed in an ASC. However, we expressed concerns that allowing payment for office-based procedures under the ASC benefit could create an incentive for physicians inappropriately to convert their offices into ASCs or to move all their office surgery to an ASC.

To address this concern, we proposed to limit payment for office-based procedures to neutralize any such incentive (see section IV.E. of this final rule). We also proposed in new § 416.171(d) to set forth rules governing the payment of office-based procedures in ASCs. We specifically invited comment regarding the effect on the Medicare program, and on practice patterns for ambulatory surgery generally, of our proposal to allow ASC payment for office-based procedures that historically have been excluded from the ASC list of covered surgical procedures.

As we discussed in the August 2006 proposed rule, we proposed to limit payment for office-based procedures in ASCs in an attempt to mitigate potentially inappropriate migration of services from the physician office setting to the ASC. Alternatively, we acknowledged that we could entirely exclude office-based procedures or procedures that require relatively inexpensive resources to perform from the ASC list of covered surgical procedures.

Comment: Many commenters supported our proposal to not exclude from ASC payment those procedures that are performed most of the time in the physician's office setting. Numerous commenters requested that the payment rate for those procedures be set at a percentage of the OPPS amount, applying the same payment methodology under the revised ASC payment system as for all other surgical procedures not excluded from ASC payment. The commenters believed that the proposed treatment of office-based procedures is unfair because, when any of those procedures would be performed in the ASC setting, that facility site would be necessary due to an individual beneficiary's need for the higher acuity care setting. Therefore, the commenters concluded that the same level of payment, in relationship to OPPS payment for those procedures, should be made for office-based procedures as for other covered ASC procedures that are not office-based. Furthermore, commenters contended that there would be very little change in surgical practice patterns under the revised ASC payment system, and that procedures currently performed predominantly in physicians' offices would not move to ASC settings as a result of our proposal to provide payment for those procedures in ASCs.

Response: We appreciate the commenters' support for our proposal to not exclude office-based surgical procedures from ASC payment under the revised ASC payment system. Based on both our final definition of surgical procedures and our final safety and overnight stay criteria to be used in evaluating procedures for exclusion from ASC payment, we see no reason to exclude surgical procedures that are currently commonly performed in physicians' offices from payment under the revised ASC payment system. We believe there are a variety of reasons that may contribute to the choice of a particular care setting for the treatment of an individual beneficiary, including the patient's surgical risk, the geographic location of the beneficiary and physician, individual physician practice patterns and preferences, the availability of specialty ASCs, and others. We do not believe that individuals receiving surgical procedures in ASCs routinely require care that is of such greater acuity than care provided in the office-based setting that the facility resources are significantly and systematically increased when those procedures that are primarily office-based are performed occasionally in ASCs. While it may be true that some more acute cases are treated in ASCs rather than in physicians' offices, we continue to believe that the structure of payments should not provide a financial incentive for treatment in the ASC facility setting. Furthermore, this policy is consistent with the averaging principle that is common to all prospective payment systems; payment is based on the resources that are required to treat the typical case, and payment for the treatment of a specific Medicare beneficiary may, therefore, be higher than the costs of treating less severe cases but lower than the costs of treating more acute cases.

We believe that including these office-based procedures on the ASC list of covered surgical procedures will ensure Medicare beneficiary access to these services in the most appropriate ambulatory or outpatient setting. Our final payment policy for these procedures, along with public comments and our responses, is discussed in section IV.E. of this final rule, and the related payment rules are set forth in § 416.171(d).

After considering the public comments received, we are finalizing our proposal, without modification, to provide payment under the revised ASC payment system for surgical procedures that are currently performed predominantly in physicians' offices and that may be safety performed in ASCs, without requiring an overnight stay.

D. Specific Surgical Procedures Excluded From Payment under the Revised ASC Payment System

In Tables 44 and 45 of the August 2006 proposed rule (71 FR 49640 through 49646), we listed the HCPCS codes and short descriptors for surgical procedures that, in addition to those that comprised the OPPS inpatient list in Addendum E to the August 2006 proposed rule, we proposed to exclude from ASC payment on or after January 1, 2008, because they pose a significant safety risk or are expected to require an overnight stay. Table 44 included those surgical procedures proposed for exclusion from payment because at least 80 percent of Medicare cases are performed on an inpatient basis, while Table 45 listed those surgical procedures proposed for exclusion from payment because they require an overnight stay. In section III.A.2. of this final rule, we discuss our final rationale for excluding surgical procedures from ASC payment. We note that because our final policy, as discussed above, for the revised ASC payment system does not automatically exclude from payment those procedures for which at least 80 percent of Medicare cases are performed on an inpatient basis, all procedures listed in Table 44 of the August 2006

proposed rule were reviewed again for this final rule as described below, in the context of our final exclusionary patient safety and overnight stay criteria.

For many of the procedures listed in Table 45 of the August 2006 proposed rule, 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 of the August 2006 proposed rule, we defaulted to the one characteristic that is common to all of the codes listed. That is, we believed that, at a minimum, prevailing medical practice would dictate the provision of overnight care following each of the procedures listed in Table 45 of the August 2006 proposed rule. We acknowledged that we had to exercise a degree of clinical judgment in identifying those procedures that we proposed to exclude from ASC payment. Therefore, we solicited comments on the appropriateness of excluding the procedures in Table 45 from payment under the revised payment system. We requested that commenters who disagreed with a specific procedure's proposed exclusion from payment submit clinical evidence that demonstrates that the criteria we proposed in proposed new § 416.166 of the regulations are not factors when the procedure is performed in the majority of cases. We asked that commenters also provide data to support any assertion that the preponderance of Medicare beneficiaries upon whom the procedure is performed would not be expected to require overnight care or monitoring following the surgery. We noted in the proposed rule that simply asserting that the procedure could be safely performed in an ASC, without providing corroborative evidence and data, would not furnish us with sufficient information upon which to make an informed decision.

Comment: Several commenters requested that, if CMS decided not to adopt less than 24 hours as its definition of an overnight stay, CMS should revise the list of proposed excluded procedures that were included in Table 45 of the August 2006 proposed rule on the basis of their overnight stay requirement. The commenters disagreed with CMS' determinations that all of those procedures required at least active medical monitoring at midnight following the procedure. Many commenters provided specific recommendations regarding surgical services that they believed should not be excluded from payment under the revised ASC payment system. In addition, several commenters identified a number of procedures not on the OPPS inpatient list that CMS proposed to exclude from ASC payment but that were not displayed in Table 44 or Table 45 of the proposed rule and for which CMS provided no rationale for their exclusion.

Response: In response to these procedure-specific comments and to those comments that reflected the belief that all procedures not on the OPPS inpatient list should be payable under the revised ASC payment system, we reviewed a subset of all of the surgical procedures that we proposed to exclude from payment under the revised ASC payment system, identified as described below. This included reassessing the treatment of those codes that were proposed to be excluded but were inadvertently left out of Table 44 or Table 45 in the August 2006 proposed rule. To conduct this comprehensive review, we identified all codes within the surgical range of CPT codes that met all of the following criteria: (1) Not proposed for the CY 2008 list of ASC covered surgical procedures (Addendum BB to the August 2006 proposed rule); (2) not included on the CY 2007 OPPS inpatient list; (3) not packaged under the OPPS; (4) not CPT unlisted surgical procedure codes; and (5) recognized for separate payment under the OPPS. Elimination of all CPT codes not meeting these criteria yielded about 750 procedures designated for a second review by our medical advisors, in order to finalize their treatment under the CY 2008 revised ASC payment system.

Our clinical staff evaluated each of those procedures using all available claims and physician pricing data, as well as their clinical judgment and the public comments, to determine which procedures would be expected to require monitoring at midnight of the day on which the surgical procedure was performed or that otherwise would pose a significant safety risk to the typical Medicare beneficiary. Table 2 below, which provides an illustrative list of all surgical procedures excluded from ASC payment under the revised ASC payment system, reflects the final outcome of that comprehensive review process. In all, we are not excluding 17 of the procedures that we had initially proposed for exclusion from payment under the revised ASC payment system. The procedures for which we made a different final determination than our proposal regarding the appropriateness of their performance in ASCs include procedures from virtually all specialty areas within the surgical range, from dermatology to gastroenterology to ophthalmology. In addition, we reviewed all Category III CPT codes and Level II HCPCS codes in the context of the public comments and our final policy for the revised ASC payment system and concluded that 29 of these codes, in addition to those HCPCS codes on the CY 2007 ASC list of covered procedures, are appropriate for performance in ASCs under the revised payment system.

Comment: A number of commenters requested that CMS exclude additional procedures from the ASC list of covered surgical procedures. Specifically, several commenters requested that CMS exclude the procedures listed in Table 1 below, because they believed that they pose significant safety risks to beneficiaries when performed in ASCs. They stated that all of the procedures listed in Table 1 would violate at least one of the proposed procedure review criteria by involving major blood vessels or prolonged invasion of body cavities. Further, one commenter suggested that some of the procedures (as listed, CPT codes 35473 through 37650) should be excluded, because they involve femoral access and could require thrombolytic therapy.

TABLE 1.—SPECIFIC PROCEDURES THAT COMMENTERS REQUESTED BE EXCLUDED FROM ASC PAYMENT

HCPCS code	Short descriptor
21215 ...	Lower jaw bone graft.
32002 ...	Treatment of collapsed lung.
33206 ...	Insertion of heart pacemaker.
33214 ...	Upgrade of pacemaker system.
33215 ...	Reposition pacing-defib lead.
33216 ...	Insert lead pace-defib, one.
33217 ...	Insert lead pace-defib, dual.
33218 ...	Repair lead pace-defib, once.
33220 ...	Repair lead pace-defib, dual.
33222 ...	Revise pocket, pacemaker.
33223 ...	Revise pocket, pacing-defib.
33224 ...	Insert pacing lead & connect.
33225 ...	L ventric pacing lead add-on.
33226 ...	Reposition L ventric lead.
33234 ...	Removal of pacemaker system.
35473 ...	Repair arterial blockage.
35474 ...	Repair arterial blockage.
35475 ...	Repair arterial blockage (non-dialysis).
35476 ...	Repair venous blockage (non-dialysis).
35492 ...	Artherectomy, perc.
35761 ...	Exploration of artery/vein.
37205 ...	Transcath IV stent, perc.
37206 ...	Transcath IV stent/perc addl.
37250 ...	IV U.S. first vessel add-on.
37251 ...	IV U.S. each add vessel add-on.
37650 ...	Revision of major vein.
40700 ...	Repair cleft lip/nasal.
40701 ...	Repair cleft lip/nasal.
42200 ...	Reconstruct cleft palate.
42205 ...	Reconstruct cleft palate.
42210 ...	Reconstruct cleft palate.

TABLE 1.—SPECIFIC PROCEDURES THAT COMMENTERS REQUESTED BE EXCLUDED FROM ASC PAYMENT—Continued

HCPCS code	Short descriptor
42215 ...	Reconstruct cleft palate.
42220 ...	Reconstruct cleft palate.
G0297 ..	Insrt 1 chamb dfib pulse generator.

Response: We appreciate the commenters' concerns and conducted a comprehensive review of each of the procedures presented. We agree with the commenters that the procedures reported by CPT codes 35475 (Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or braches, each vessel); 37205 (Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), percutaneous; initial vessel); and 37206 (Transcatheter placement of an intravascular stent(s), (except coronary, carotid, and vertebral vessel), each additional vessel) should be excluded from the ASC list of covered surgical procedures because they could pose a significant safety risk to beneficiaries in ASCs. We did not include CPT code 35475 in our proposed list of covered surgical procedures under the revised ASC payment system because we, like the commenters, believe that it poses a safety risk for beneficiaries if performed in ASCs. Although we did propose to add CPT codes 37205 and 37206 to the ASC list for CY 2007, we did not finalize that proposal for CY 2007 in response to comments and continue to agree with commenters that those procedures would likely require an overnight stay.

With regard to the remaining procedures, three of them, specifically CPT codes 33222 (Revision or relocation of skin pocket for pacemaker); 33223 (Revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator); and 37650 (Ligation of femoral vein), are on the current ASC list of covered surgical procedures and have been safely performed in ASCs for some time. We do not believe that they represent a significant safety risk or are likely to require an overnight stay.

We did not propose to exclude any of the remaining procedures in Table 1 from the list of procedures for which ASCs may receive payment under the revised payment system because, based on our clinical review, we did not find that the procedures would be expected to require an overnight stay or pose a significant risk to beneficiary safety when performed in ASCs. Our review for this final rule, in consideration of the comments, did not alter our final opinion on the appropriate treatment of these other codes.

Therefore, we are finalizing our proposal, with modification, regarding specific surgical procedures that are excluded from ASC payment under the revised ASC payment system. Table 2 provides an illustrative list of CPT codes that are payable under the OPPS but that are excluded from the ASC list of covered surgical procedures. This illustrative list does not include those procedures that are on the OPPS inpatient list, packaged under the OPPS, or only reportable by CPT unlisted surgical procedure codes. All of the procedures listed in Table 2 are excluded from the list of covered surgical procedures for which Medicare will provide ASC payment under the revised ASC payment system because we believe, based on our review of each procedure's clinical characteristics, utilization data reflected in physician claims, and prevailing medical practice as reflected in the valuation of the services by the AMA/Specialty Society Relative Value Scale Update Committee (RUC), and consideration of the judgment of our medical advisors and all public comments to the proposed rule, that these surgical procedures pose a significant risk to beneficiary safety or are expected to require an overnight stay.

In this final rule, we are finalizing the addition of 793 new surgical procedures to the ASC list of covered surgical procedures for CY 2008, while we are excluding those procedures listed in Table 2 from ASC payment for CY 2008. This list will be updated for the CY 2008 revised ASC payment system through the CY 2008 OPPS/ASC annual rulemaking cycle.

TABLE 2.—ILLUSTRATIVE LIST OF SURGICAL PROCEDURES PAYABLE UNDER THE OPPS (NOT ON THE OPPS INPATIENT LIST, NOT PACKAGED UNDER THE OPPS AND NOT DESIGNATED AS CPT UNLISTED CODES) THAT ARE EXCLUDED FROM ASC PAYMENT BECAUSE THEY POSE A SIGNIFICANT SAFETY RISK OR ARE EXPECTED TO REQUIRE AN OVERNIGHT STAY

HCPCS code	Short descriptor
15170 ..	Acell graft trunk/arms/legs.
15171 ..	Acell graft t/arm/leg add-on.
15175 ..	Acellular graft, f/n/hf/g.
15176 ..	Acell graft, f/n/hf/g add-on.
19260 ..	Removal of chest wall lesion.
19307 ..	Mast, mod rad.

TABLE 2.—ILLUSTRATIVE LIST OF SURGICAL PROCEDURES PAYABLE UNDER THE OPPS (NOT ON THE OPPS INPATIENT LIST, NOT PACKAGED UNDER THE OPPS AND NOT DESIGNATED AS CPT UNLISTED CODES) THAT ARE EXCLUDED FROM ASC PAYMENT BECAUSE THEY POSE A SIGNIFICANT SAFETY RISK OR ARE EXPECTED TO REQUIRE AN OVERNIGHT STAY—Continued

HCPCS code	Short descriptor
20100 ..	Explore wound, neck.
20101 ..	Explore wound, chest.
20102 ..	Explore wound, abdomen.
21049 ..	Excis uppr jaw cyst w/repair.
21175 ..	Reconstruct orbit/forehead.
21195 ..	Reconst lwr jaw w/o fixation.
21261 ..	Revise eye sockets.
21263 ..	Revise eye sockets.
21408 ..	Treat eye socket fracture.
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.
22526 ..	Idet, single level.
22527 ..	Idet, 1 or more levels.
22612 ..	Lumbar spine fusion.
22614 ..	Spine fusion, extra segment.
22851 ..	Apply spine prosth device.
23470 ..	Reconstruct shoulder joint.
24150 ..	Extensive humerus surgery.
24151 ..	Extensive humerus surgery.
24935 ..	Revision of amputation.
25170 ..	Extensive forearm surgery.
26037 ..	Decompress fingers/hand.
27216 ..	Treat pelvic ring fracture.
27235 ..	Treat thigh fracture.
27412 ..	Autochondrocyte implant knee.
27415 ..	Osteochondral knee allograft.
27446 ..	Revision of knee joint.
27475 ..	Surgery to stop leg growth.
27524 ..	Treat kneecap fracture.
28360 ..	Reconstruct cleft foot.
29866 ..	Autgrft implnt, knee w/scope.
29867 ..	Allgrft implnt, knee w/scope.
29868 ..	Meniscal trnspl, knee w/scpe.
31292 ..	Nasal/sinus endoscopy, surg.
31293 ..	Nasal/sinus endoscopy, surg.
31294 ..	Nasal/sinus endoscopy, surg.
31600 ..	Incision of windpipe.
31601 ..	Incision of windpipe.
31610 ..	Incision of windpipe.
31785 ..	Remove windpipe lesion.
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.
32998 ..	Perq rf ablate tx, pul tumor.
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.

TABLE 2.—ILLUSTRATIVE LIST OF SURGICAL PROCEDURES PAYABLE UNDER THE OPPS (NOT ON THE OPPS INPATIENT LIST, NOT PACKAGED UNDER THE OPPS AND NOT DESIGNATED AS CPT UNLISTED CODES) THAT ARE EXCLUDED FROM ASC PAYMENT BECAUSE THEY POSE A SIGNIFICANT SAFETY RISK OR ARE EXPECTED TO REQUIRE AN OVERNIGHT STAY—Continued

HCPCS code	Short descriptor
34421 ..	Removal of vein clot.
34471 ..	Removal of vein clot.
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.
35201 ..	Repair blood vessel lesion.
35206 ..	Repair blood vessel lesion.
35226 ..	Repair blood vessel lesion.
35231 ..	Repair blood vessel lesion.
35236 ..	Repair blood vessel lesion.
35256 ..	Repair blood vessel lesion.
35261 ..	Repair blood vessel lesion.
35266 ..	Repair blood vessel lesion.
35286 ..	Repair blood vessel lesion.
35321 ..	Rechanneling of artery.
35458 ..	Repair arterial blockage.
35459 ..	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.
35485 ..	Atherectomy, open.
35490 ..	Atherectomy, percutaneous.
35491 ..	Atherectomy, percutaneous.
35493 ..	Atherectomy, percutaneous.
35494 ..	Atherectomy, percutaneous.
35495 ..	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.
35883 ..	Revise graft w/nonauto graft.
35884 ..	Revise graft w/vein.
35903 ..	Excision, graft, extremity.
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.
37205 ..	Transcath iv stent, precut.
37206 ..	Transcath iv stent/perc addl.
37207 ..	Transcath iv stent, open.
37208 ..	Transcath iv stent/open addl.
37209 ..	Change iv cath at thromb tx.
37210 ..	Embolization uterine fibroid.
37565 ..	Ligation of neck vein.
37600 ..	Ligation of neck artery.
37605 ..	Ligation of neck artery.
37606 ..	Ligation of neck artery.
37615 ..	Ligation of neck artery.
37620 ..	Revision of major vein.
38120 ..	Laparoscopy, splenectomy.
38240 ..	Bone marrow/stem transplant.
38720 ..	Removal of lymph nodes, neck.
39400 ..	Visualization of chest.
42225 ..	Reconstruct cleft palate.
42227 ..	Lengthening of 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.
43647 ..	Lap impl electrode, antrum.
43648 ..	Lap revise/remv eltrd antrum.
43651 ..	Laparoscopy, vagus nerve
43652 ..	Laparoscopy, vagus nerve.
43752 ..	Nasal/orogastric w/stent.
43830 ..	Place gastrostomy tube.
43831 ..	Place gastrostomy tube.
44180 ..	Lap, enterolysis.
44186 ..	Lap, jejunostomy.
44206 ..	Lap part colectomy w/stoma.
44207 ..	Lcolectomy/coloproctostomy.
44208 ..	Lcolectomy/coloproctostomy.
44213 ..	Lap, mobil splenic fl add-on.
44500 ..	Intro, gastrointestinal tube.
44901 ..	Drain app abscess, precut.
44970 ..	Laparoscopy, appendectomy.
45541 ..	Correct rectal prolapse.
47011 ..	Percut drain, liver lesion.
47370 ..	Laparo ablate liver tumor rf.
47371 ..	Laparo ablate liver cryosurg.
47490 ..	Incision of gallbladder.
48511 ..	Drain pancreatic pseudocyst.
49021 ..	Drain abdominal abscess.
49041 ..	Drain, percut, abdom abscess.
49061 ..	Drain, percut, retroper absc.
49200 ..	Removal of abdominal lesion.
49323 ..	Laparo drain lymphocele.
49324 ..	Lap insertion perm ip cath.
49325 ..	Lap revision perm ip cath.
49326 ..	Lap w/omentopexy add-on.
49435 ..	Insert subq exten to ip cath.
49436 ..	Embedded ip cath exit-site.
49491 ..	Rpr hern preemie reduce.
49492 ..	Rpr ing hern premie, blocked.
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.
50542 ..	Laparo ablate renal mass.
50543 ..	Laparo partial nephrectomy.
50544 ..	Laparoscopy, pyeloplasty.
50945 ..	Laparoscopy, ureterolithotomy.
51990 ..	Laparo urethral suspension.
53500 ..	Urethrlys, transvag w/ scope.
57106 ..	Remove vagina wall, partial.
57107 ..	Remove vagina tissue, part.
57109 ..	Vaginectomy partial w/nodes.
57120 ..	Closure of vagina.
57282 ..	Colpopexy, extraperitoneal.
57283 ..	Colpopexy, intraperitoneal.
57284 ..	Repair paravaginal defect.
57292 ..	Construct vagina with graft.
57295 ..	Change vaginal graft.
57310 ..	Repair urethrovaginal lesion.
57330 ..	Repair bladder-vagina lesion.
57335 ..	Repair vagina.
57425 ..	Laparoscopy, surg, colpopexy.
57555 ..	Remove cervix/repair vagina.
58260 ..	Vaginal hysterectomy.
58262 ..	Vag hyst including t/o.
58263 ..	Vag hyst w/t/o & vag repair.
58270 ..	Vag hyst w/enterocele repair.
58290 ..	Vag hyst complex.
58291 ..	Vag hyst incl t/o, complex.
58292 ..	Vag hyst t/o & repair, compl.
58294 ..	Vag hyst w/enterocele, compl.
58541 ..	Lsh, uterus 250 g or less.
58542 ..	Lsh w/t/o ut 250 g or less.
58543 ..	Lsh uterus above 250 g.
58544 ..	Lsh w/t/o uterus above 250 g.
58553 ..	Laparo-vag hyst, complex.
58554 ..	Laparo-vag hyst w/t/o, compl.
58770 ..	Create new tubal opening.
58823 ..	Drain pelvic abscess, precut.
58920 ..	Partial removal of ovary(s).
58925 ..	Removal of ovarian cyst(s).
59030 ..	Fetal scalp blood sample.
59074 ..	Fetal fluid drainage w/us.
59409 ..	Obstetrical care.
59612 ..	Vbac delivery only.
60210 ..	Partial thyroid excision.
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.
60502 ..	Re-explore parathyroids.
60512 ..	Autotransplant parathyroid.
60520 ..	Removal of thymus gland.
61623 ..	Endovasc tempory vessel occl.
61626 ..	Transcath occlusion, non-cns.
61720 ..	Incise skull/brain surgery.
62000 ..	Treat skull fracture.
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.

TABLE 2.—ILLUSTRATIVE LIST OF SURGICAL PROCEDURES PAYABLE UNDER THE OPPS (NOT ON THE OPPS INPATIENT LIST, NOT PACKAGED UNDER THE OPPS AND NOT DESIGNATED AS CPT UNLISTED CODES) THAT ARE EXCLUDED FROM ASC PAYMENT BECAUSE THEY POSE A SIGNIFICANT SAFETY RISK OR ARE EXPECTED TO REQUIRE AN OVERNIGHT STAY—Continued

HCPCS code	Short descriptor
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.
64448 ..	Nblock inj fem, cont inf.
64449 ..	Nblock inj, lumbar plexus.
64804 ..	Remove sympathetic nerves.
64910 ..	Nerve repair w/allograft.
64911 ..	Neurorraphy w/vein autograft.
69725 ..	Release facial nerve.
69955 ..	Release facial nerve.
69960 ..	Release inner ear canal.

IV. Ratesetting Methodology for the Revised ASC Payment System

A. Overview of Current ASC Payment System

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 also can be safely performed in an ASC and to review and update the list of procedures paid under the ASC payment system at least every 2 years.

Under the existing ASC 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. We refer readers to section I.B. of this final rule for further history regarding the establishment of standard overhead amounts for ASC payment. The standard overhead amounts under the existing ASC payment system for procedures on the ASC list of covered surgical procedures 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 payment system are explained in the February 8, 1990 **Federal Register** (55 FR 4526).

The existing ASC payment system consists of 9 standard overhead amounts ranging from $333 to $1,339, based on the data collected in the 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 are included in active NTIOL classes. Medicare also makes separate payment for implantable prosthetic devices and implantable durable medical equipment (DME) that are surgically inserted at an ASC under the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule. Payment for all other facility services that are directly related to performing a surgical procedure is packaged into the prospectively determined ASC payment for the covered surgical procedure.

Section 5103 of Public Law 109–171 requires us to substitute the OPPS payment amount for the ASC standard overhead amount for surgical procedures performed in an ASC on or after January 1, 2007, but prior to the revised ASC payment system, when the ASC standard overhead amount exceeds the OPPS payment amount for the procedure in that year. In Addendum AA to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68243 through 68283), we identify the HCPCS codes on the CY 2007 ASC list for which the CY 2007 ASC payments are capped at the OPPS payment amounts in accordance with the provisions of section 5103 of Public Law 109–171, based on a comparison of the final CY 2007 OPPS payment rates and the ASC standard overhead amounts that are effective in CY 2007.

Except for screening flexible sigmoidoscopy and screening colonoscopy services, payment for ASC 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. As required by section 1834(d) of the Act, the coinsurance for screening flexible sigmoidoscopies and colonoscopies is 25 percent and the amounts paid by Medicare must be 75 percent of the standard fee.

Medicare currently accounts for geographic wage variations when calculating individual ASC payments by applying the relevant inpatient prospective payment system (IPPS) wage index values and localities that were established under the IPPS prior to implementation of the new Core Based Statistical Areas (CBSAs) issued by the Office of Management and Budget (OMB) in June 2003 to 34.45 percent of the national ASC standard overhead amount. The 1986 ASC survey data are the basis for attributing 34.45 percent of ASC facility costs to labor costs.

Section 1833(i)(2)(C) of the Act requires the Secretary to update ASC payment rates using the CPI–U (U.S. city average) (CPI–U) if the Secretary has not otherwise updated the amounts under the revised ASC payment system. As amended by Public Law 108–173, section 1833(i)(2)(C) of the Act provides 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. Public Law 108–173 further amended section 1833(i)(2)(C) of the Act to require us in FY 2004, beginning April 1, 2004, to increase ASC payment rates using the CPI–U as estimated for the 12-month period ending March 31, 2003, minus 3.0 percentage points. Public Law 108–173 also requires that the CPI–U adjustment factor equal zero percent in FY 2005, the last quarter of CY 2005, and each of CYs 2006 through 2009.

Section 141(b) of the Social Security Act Amendments of 1994, Public Law 103–432, requires us to establish a process for considering requests for review of the appropriateness of the payment amount provided under section 1833(i)(2)(A)(iii) of the Act for IOLs to ensure that the ASC payment for the insertion procedure is reasonable and related to the cost of acquiring a lens that belongs to a class of NTIOLs. In the CY 2007 OPPS/ASC proposed rule that was published August 23, 2006 (71 FR 49631 through 49635), we proposed changes to the process for recognizing IOLs as belonging to a new NTIOL class. In the subsequent CY 2007 OPPS/ASC final rule with comment period (71 FR 68175 through 68181), we finalized the proposed changes to that process, beginning with requests for review for establishing new NTIOL classes for CY 2008 payment.

The revised ASC payment system that we are finalizing in this rule will implement requirements set forth in section 626 of Public Law 108–173. The

revised payment system mandated by section 626(d) of Public Law 108–173 requires us to take into account recommendations in a report to Congress prepared by the GAO. As mentioned earlier, that report (GAO–07–86) was published on November 30, 2006. Its methodology, findings, and recommendations are summarized in section II.B. of this final rule. Specific ASC payment system issues considered in the GAO Report are discussed in the individual sections below under the related topic areas.

B. ASC Relative Payment Weights Based on APC Groups and Relative Payment Weights Established Under the OPPS

As we stated in the August 2006 proposed rule for the revised ASC payment system (71 FR 49647), we considered several strategies and methodologies for setting ASC payment rates under a revised payment system. These options included requiring ASCs to submit modified cost reports as a basis for establishing ASC costs, expanding the number and payment range of the current ASC payment groups, basing payments to ASCs on the relative weights for surgical services established under the MPFS, basing payments to ASCs on the relative weights for surgical services established under the Medicare OPPS, as suggested in Public Law 108–173, or basing 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 reviewing the advantages and disadvantages of each of these approaches, in the August 2006 proposed rule we proposed, within the parameters of section 626 of Public Law 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 in 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 Public Law 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 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 all services furnished in connection with outpatient surgical procedures.

Third, Public Law 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 that, of the 150 highest volume surgical procedures furnished in HOPDs, 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 CMS sets payments and determines what is payable under the ASC benefit.

We explained in the August 2006 proposed rule that the OPPS payment rates are based on relative payment weights, which are updated annually based on the most recent year of hospital outpatient claims data and hospitals' latest Medicare cost reports. 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 Advisory Panel on Ambulatory Payment Classification Groups (APC Panel) and as a result of comments received during the OPPS annual rulemaking cycles.

Moreover, we believed that the APC groups had matured with respect to their clinical and resource homogeneity, and the relativity in resource utilization among APCs containing surgical procedures had stabilized. Thus, we concluded in the proposed rule that the APC groups and their relative weights were reasonable and appropriate models for grouping outpatient surgical procedures and determining the relativity of the ASC payment weights under the revised payment system. For example, whether performed in an HOPD or in an ASC, we believed the time and facility resources required to perform a routine laparoscopic hernia repair described by CPT code 49650 (Laparoscopy, surgical; repair initial inguinal hernia), with a CY 2007 OPPS relative payment weight of 43.5488, were approximately 5 times higher than those required to perform a diagnostic colonoscopy described by CPT code 45378 (Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)), with a CY 2007 OPPS relative payment weight of 8.7686. Thus, we believed that the relative payment weights established under the OPPS for procedures performed in the hospital outpatient setting reasonably reflected the relative facility resources required for such procedures and did so with sufficient coherence to be applicable to other ambulatory sites of service. Taking all these factors into account, we proposed 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 proposed to establish provisions in proposed new Subpart F, §§ 416.167 and 416.171, to reflect these proposed changes for calculating the ASC payment rates beginning January 1, 2008.

As further discussed in section II.B. of this final rule, on November 30, 2006, the GAO published the report mandated by section 626(d) of Public Law 108–173 (GAO–07–86), where it determined that the APC groups of the OPPS accurately reflect the relative costs of procedures performed in ASCs. It concluded that the APC groups in the OPPS reflect the relative costs of surgical procedures performed in ASCs in the same way that they reflect the relative costs of the same procedures when they are performed in HOPDs. Therefore, the GAO recommended that the APC groups could be applied to procedures performed in ASCs, and the OPPS could be used as the basis for an ASC payment system, thereby eliminating the need for ASC surveys and providing for an annual revision of the ASC payment groups. At its December 2006 meeting, the PPAC recommended that CMS apply any payment policies uniformly to both

ASCs and HOPDs as appropriate, confirming its belief that the OPPS and the revised ASC payment system could be closely linked.

We received a number of comments on our proposal to use the OPPS relative payment weights as the basis for establishing relative payment weights under the revised ASC payment system. A summary of the comments and our responses follow.

Comment: Many commenters agreed that using the OPPS APCs as a ''grouper'' and the APC relative payment weights to establish ASC payment rates for surgical procedures paid under the revised ASC payment system is appropriate because a significant number of surgical procedures furnished in the hospital outpatient setting are also performed in ASCs. Some commenters argued that because ASCs provide many similar procedures that are also performed in HOPDs and often utilize the same equipment, supplies, and clinical labor in performing these procedures, the relative costs of performing the procedures should be similar, if not identical, in both settings. Moreover, the commenters generally agreed that creating an ASC payment system that parallels the OPPS would promote transparency across sites of service in the area of outpatient surgery and would also promote greater alignment and coordination between the OPPS and the revised ASC payment system, including providing for the annual updating of payment weights in the ASC payment system.

Some commenters requested that CMS apply different conversion factors to the OPPS relative payment weights for specific types of procedures to calculate their ASC payment rates, because they suggested that the OPPS relativity was not correct for some services provided in single specialty ASCs (for example, gastroenterology and pain management procedures). They believed that the OPPS APC weights, based on all hospital services rather than just surgical services, may be flawed and that additional analyses of relative hospital and ASC costs are needed. They recommended that CMS develop firm data on the differences between hospital outpatient and ASC costs and the magnitude of those differences for numerous services before finalizing significant changes in ASC payments for procedures. One commenter specifically discussed a study commissioned by MedPAC in which RAND found that no single outpatient surgical setting, ASCs or HOPDs, had consistently higher rates of patient characteristics that would be expected to increase facility costs. Analyses by another commenter found that among a subset of gastrointestinal (GI) procedures, the majority of surgical CPT codes describing those procedures received OPPS payments that were less than hospitals' median costs for the individual procedures.

Response: We appreciate the commenters' general support for basing the revised ASC payment system relative weights on the OPPS APC groups and their relative weights. As discussed in detail in section II.B. of this final rule, in its November 2006 report on ASC payment, the GAO found that the APC groups in the OPPS accurately reflect the relative costs of procedures performed in ASCs. The GAO analyses also demonstrated that there is less variation in the ASC setting between individual procedures' costs and the costs of their assigned APC groups than there is in the HOPD setting, and that when compared to the median cost of the same APC group, procedures performed in ASCs had substantially lower costs than those same procedures performed in HOPDs.

The GAO findings were based upon data for all procedures performed in ASCs in CY 2004, as reported by those ASCs responding to the GAO survey. In view of the GAO's confirmation that the APC groups accurately reflect the relative costs of these procedures performed in ASCs in the same way that they reflect the relative costs of the same procedures when they are performed in HOPDs, substantiating a key assumption underlying our proposal for the revised ASC payment system, we do not believe there is a compelling rationale for using different ASC conversion factors to develop payment rates for various procedures under the revised ASC payment system. Applying more than one ASC conversion factor to different procedures would imply that we believe the OPPS APC payment weight relativity is not applicable to the ASC setting, contrary to our proposal and the GAO study results. APCs currently serve as a ''grouper'' for the OPPS and, as such, the payment for any given procedure under the OPPS does not specifically reflect the cost of that procedure in any one facility. Instead, the APC relative payment weights under the OPPS are developed based on the median cost of all single claims for all procedures assigned to each APC. Prospectively established APC payment rates provide an averaging effect on OPPS payments for individual services. With the significant expansion of covered surgical procedures eligible for ASC payment that we are finalizing in this final rule for the revised ASC payment system as discussed in section III. of this final rule, in many cases where one service in an APC is an ASC procedure, most of the other procedures assigned to the same APC will also be paid in the ASC setting. Thus, under the revised payment system, ASCs generally will have the potential to provide a mix of individual services assigned to those APCs that is similar to the mix of OPPS procedures attributable to certain APCs and, in many cases, all of the procedures assigned to certain APCs under the OPPS will also be ASC covered surgical procedures. We believe this uniform approach under the revised ASC payment system is fully consistent with the recommendation of the PPAC that we apply payment policies consistently to both ASCs and HOPDs, as appropriate. It also generally treats procedures performed in ASCs consistently for purposes of developing ASC payment rates under the revised ASC payment system, in accordance with the PPAC recommendation that we adopt a systematic and adaptable means of fairly reimbursing ASCs for their services.

While information provided by the commenters clearly demonstrated that some specific groups of procedures would experience a significant decrease in payment under the revised ASC payment system as compared with the existing payment structure, we are not convinced that the information we received contradicts the premise of our proposal and the GAO findings that the relativity of costs observed in HOPDs could appropriately be used as the basis for the relative payment weights in the revised ASC payment system. We also continue to see no clinical basis that would support the differential relativity of costs for various procedures performed in the ASC or HOPD settings.

While applying a single conversion factor to the OPPS relative weights may result in decreases to ASC payments for some services commonly provided in single specialty ASCs, we also believe that this approach should result in facilities receiving more appropriate payments for ASC services in general, where those payments more accurately reflect the facility resources required for their performance. As discussed further in section IV.J. of this final rule, our final policy of a 4-year transition to phase in the revised ASC payment system should mitigate the potential disruption in care that could be associated with significant increases or decreases in payments for specific surgical procedures under the revised payment system. Individual ASCs will have a longer period of time to evaluate and potentially modify the breadth of

surgical procedures they provide based on the expanded list of covered surgical procedures and the final policies of the revised ASC payment system. Further, our final ASC policies for payment of device=intensive procedures and covered ancillary services that more closely align the ASC and OPPS systems may moderate the magnitude of differences between current ASC payments and those under the revised payment system for individual surgical procedures. We do not believe that it would be appropriate to modulate changes in payment under the revised system by differentially adjusting the payment weights or the conversion factor for various types of services because, consistent with the GAO recommendation, we believe the OPPS relative payment weights upon which the revised ASC payment system is based appropriately reflect the relativity in ASC resource costs associated with different surgical procedures. We believe that the final payment policies for the revised payment system result in appropriate and equitable payments, and thus, we see no rationale for applying adjustments that are counter to the principles of a prospective payment system.

After considering the public comments received, we are finalizing our proposal, without modification, to establish the relative payment weights under the revised ASC payment system for most covered surgical procedures based on their OPPS APC relative payment weights for the same calendar year, with application of a single ASC conversion factor to determine the national unadjusted ASC payment rates, as set forth in §§ 416.167 and 416.171. Several exceptions to this general policy are discussed elsewhere in this final rule, specifically in sections IV.C. and IV.E. of this preamble.

C. Packaging Policy

1. General Policy

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 payment the payment for a bundle of direct and indirect costs incurred by the facility to perform the surgical 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.

CMS currently applies different rules under the ASC payment system and the OPPS 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, CMS 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, CMS 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 DME, as well as additional payment for NTIOLs. Laboratory services, physicians' services, and x-ray or diagnostic procedures may also be paid separately under other Medicare Part B fee schedules. Conversely, under the OPPS, payment for prosthetic implants and implantable DME is packaged into the OPPS payment for the surgical procedure performed to insert the implants. Payments for IOLs, anesthesia materials, and implantable surgical supplies, such as stents, mesh, guidewires, pins, and catheters, are packaged into the associated surgical procedure payment under both the OPPS and the ASC payment system.

In developing the August 2006 proposed rule for the revised ASC payment system, we considered several packaging options. First, we considered making no change to the current policy regarding items and services for which payment is packaged into the ASC payment. That is, we would continue under the revised ASC payment system to package into the ASC payment all services listed at existing § 416.61(a). In addition, we would continue to pay separately, sometimes 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 Diagnostic Laboratory Fee Schedule); physician services (MPFS); and x-ray or diagnostic procedures other than those directly related to performance of the surgical procedure (MPFS).

We also considered proposing to apply the OPPS packaging rules to the ASC payment system and to pay under the revised ASC payment 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 covered surgical procedure would not be packaged into the ASC payment 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 has 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, in the August 2006 proposed rule for the revised ASC payment system, we proposed a third option (71 FR 49648). That is, we proposed to continue the current policy of packaging payment for all direct and indirect costs incurred by the facility to perform a covered surgical procedure into the ASC payment for the 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 were proposed for packaging into the ASC surgical procedure payment as listed in proposed § 416.164(a). Proposed § 416.164(a) addressed the services for which payment was proposed to be included in the ASC payment for the covered surgical procedures, and proposed § 416.164(b) addressed those services that were proposed *not* to be included in the ASC payment for the covered surgical procedures.

In addition, we proposed to cease making separate payment for implantable prosthetic devices and implantable DME inserted surgically in an ASC. Instead, under the revised payment system, we proposed to package payment for implantable prosthetic devices and implantable DME when they are surgically inserted into the ASC payment for the associated covered surgical procedure, as we do under the OPPS.

However, we proposed to continue excluding from ASC payment for covered surgical procedures the other services addressed in § 416.164(b). That is, payment for items and services for which payment is currently made under other Part B fee schedules, with the exception of implantable prosthetic devices and implantable DME, would

not be included in the ASC payment for the surgical procedure. Payment for items and services, such as physicians' professional services; 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 DME for use in the patient's home would not be included in the ASC payment for the covered surgical procedure.

We proposed this third option for a number of reasons. First, in the August 2006 proposed rule, we explained that this approach to packaging is most consistent with the principles of a prospective payment system. Second, we noted that 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, in the August 2006 proposed rule, we concluded that we did 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 services payment under the existing payment system, reduce incentives for cost-efficient delivery of services in ASCs, and increase the complexity of the revised ASC payment system.

Moreover, after 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 HOPD, 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.

We sought comments in the August 2006 proposed rule (71 FR 49648) from ASC clinical and administrative staff, and from physicians who perform surgeries in 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 specifically requested 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.

At its December 2006 meeting, the PPAC recommended that CMS apply any payment policies uniformly to ASCs under the revised ASC payment system and HOPDs under the OPPS. In the GAO Report (GAO–07–86) published on November 30, 2006, based upon its study of the 20 most frequently performed ASC procedures in CY 2004, the GAO found that many additional services were billed with surgical procedures in both the ASC and HOPD settings, but few resulted in an additional payment in one setting but not the other. In general, HOPDs were paid separately for some of the related additional services they billed with the procedures and, in the ASC setting, other Part B suppliers usually billed Medicare for those services and received payment for them. Multiple surgical procedures performed in one session were typically paid separately in both settings, occurring in similar proportions of cases and subject to the same 50-percent reduction policy for the procedure with the lower payment rate. Laboratory services were paid under the OPPS according to the Clinical Diagnostic Laboratory Fee Schedule (CLFS) rates and were billed by another Medicare Part B supplier when provided in the context of a surgical procedure performed in an ASC. Similarly, some radiology services were paid separately under the OPPS, but when those radiology services were performed with procedures provided in the ASC setting, those services generally were furnished and billed by another Part B supplier. Anesthesia services in both settings were usually billed by another Part B supplier. While individual drugs were billed under the OPPS for most procedures, the GAO found that none of those individual drugs were separately payable in the HOPD setting, just as their payment was packaged in ASCs. Thus, the GAO concluded that there were many similarities in the additional services billed in the ASC or HOPD settings with the top 20 ASC procedures. Furthermore, the GAO found that, in the context of the existing ASC payment system, CMS generally made separate payment for similar additional services in both settings, although sometimes to other Part B suppliers than to the ASCs themselves.

We also note that we proposed, consistent with section 141(b) of the Social Security Act Amendments of 1994, Public Law 103–432, to continue to provide adjustment to payment amounts for NTIOLs under the revised ASC payment system as set forth in Subpart G that we finalized in the CY 2007 OPPS/ASC final rule with comment period.

We received numerous comments on our proposed packaging policies for the revised ASC payment system. The commenters submitted many suggestions regarding the various approaches that they believed CMS should follow when finalizing the packaging policies for certain items and services under the revised ASC payment system. A summary of the comments and our responses follow.

Comment: In general, many of the commenters agreed with CMS' proposal to continue to package under the revised ASC payment system payment for various items and services that are currently packaged under the OPPS and the existing ASC payment system. They recommended that CMS adopt its proposal to provide packaged payment for the costs of many items and services that are directly related to the provision of surgical procedures, such as facility overhead, operating and recovery room use, nursing and technician services, administrative and housekeeping items and services, appliances and equipment, materials for anesthesia, IOLs, surgical dressings, supplies, splints, and casts. They acknowledged that the statute requires that payment to ASCs for IOLs (other than NTIOLs which receive a supplemental payment) must be packaged into the ASC payment for IOL insertion procedures. In addition, the commenters agreed that CMS should continue to exclude from payment as part of the ASC payment for covered surgical procedures some items and services that are paid under other Part B fee schedules, specifically the professional services of physicians and nonphysician practitioners paid under the MFPS and laboratory services paid under the CLFS. Further, the commenters agreed that CMS should continue to provide additional payment for NTIOLs.

The commenters who supported continued packaging of the items and services described above generally provided those recommendations in the context of their broader recommendation to apply the same packaging policies under the revised ASC payment system as under the

OPPS, because the proposed payment rates under the revised ASC payment system were based upon the OPPS payment groups. They argued that parallel packaging policies were most consistent with promoting transparency between the two systems and minimizing any payment incentives to shift sites of service for various procedures. They also believed that this approach is the most appropriate, given the proposal to base the rates in the revised ASC payment system on the OPPS relative payment weights, with application of a single conversion factor. The commenters asserted that consistent packaging policies would ensure that some payment was made for the costs of all items and services used by facilities in performing surgical procedures, and that there was no duplicate payment for these items under either the OPPS or the revised ASC payment system.

MedPAC supported the proposal to expand the ASC payment bundles in the revised payment system by packaging payment for implantable prosthetics and DME, but recommended that CMS make the payment bundles under the revised ASC payment system and the OPPS even more compatible by expanding the payment bundles in the OPPS. MedPAC noted that different bundling policies under the two payment systems may lead to different relative payment amounts in each setting, even if the base payment rates share the same relative values in both settings.

Response: We appreciate the commenters' support for continuing to package payment under the revised ASC payment system for those items and services that also receive packaged payment under the OPPS. The commenters' recommendations are consistent with the PPAC recommendation that we apply payment policies uniformly across the two systems. We note that any changes to the OPPS payment bundles are outside the scope of this final rule for the revised ASC payment system. Such changes would have to be proposed and finalized through the OPPS annual rulemaking cycle, and we will keep MedPAC's recommendations in mind for future OPPS updates.

As set forth in final § 416.163, payment is made under the revised ASC payment system for ASC services furnished in connection with covered surgical procedures. As set forth in revised § 416.2, ASC services include both facility services, which are defined as items and services that are furnished in connection with a covered surgical procedure performed in an ASC and for which payment is packaged into the ASC payment for the covered surgical procedure, and covered ancillary services, which are defined as those items and services that are integral to a covered surgical procedure and for which separate payment may be made under the revised ASC payment system.

After considering all public comments received, we are finalizing, with modification, our proposal to provide packaged payment for ASC facility services into the ASC payment for covered surgical procedures under the revised ASC payment system. That is, we will continue to identify as within the scope of ASC facility services for which payment is packaged into the payment for covered surgical procedures as set forth in final § 416.164(a) the following: nursing, technician, and related services; use of the facility where the surgical procedures are performed; laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver; drugs and biologicals for which separate payment is not allowed under the OPPS; medical and surgical supplies not on pass-through status under the OPPS; equipment; surgical dressings; implanted prosthetic devices and related accessories and supplies not on pass-through status under the OPPS, including IOLs; implanted DME and related accessories and supplies not on pass-through status under the OPPS; splints and casts and related devices; radiology services for which separate payment is not allowed under the OPPS and other diagnostic tests or interpretive services that are integral to a surgical procedure; administrative, recordkeeping, and housekeeping items and services; materials, including supplies and equipment for the administration and monitoring of anesthesia; and supervision of the services of an anesthetist by the operating surgeon. Under the revised ASC payment system, the above items and services fall within the scope of ASC facility services, and we will package payment for them into the ASC payment for the covered surgical procedure in order to promote efficient use of resources. We will continue to provide a payment adjustment for insertion of an IOL approved as belonging to a class of NTIOLs, for the 5-year period of time established for that class, as set forth in Subpart G and new § 416.172(g) for the revised ASC payment system.

As a modification to our proposal, under the final policy of the revised ASC payment system, covered ancillary services that are integral to a covered ASC surgical procedure will be allowed separate payment. These covered ancillary services, which are outside of the scope of ASC facility services defined at § 416.2 and described at new § 416.164(a) for which payment is packaged into the ASC payment for covered surgical procedures, are defined at § 416.2 and described at new § 416.164(b) as follows: brachytherapy sources; certain implantable items that have pass-through status under the OPPS; certain items and services that we designate as contractor-priced (payment rate is determined by the Medicare contractor) including, but not limited to, the procurement of corneal tissue; certain drugs and biologicals for which separate payment is allowed under the OPPS; and certain radiology services for which separate payment is allowed under the OPPS. Public comments on the proposed rule and our responses regarding these specific items and services are discussed later in this section.

We will consider to be outside the scope of ASC services, as set forth in § 416.164(c), the following items and services, including, but not limited to: physicians' services (including surgical procedures and all preoperative and postoperative services that are performed by a physician); anesthetists' services; radiology services (other than those integral to performance of a covered surgical procedure); diagnostic procedures (other than those directly related to performance of a covered surgical procedure); ambulance services; leg, arm, back, and neck braces other than those that serve the function of a cast or splint; artificial limbs; and nonimplantable prosthetic devices and DME.

2. Policies for Specific Items and Services

Although in the August 2006 proposed rule we proposed to package payment for a broad array of items and services under the revised ASC payment system into the ASC payment for a covered surgical procedure as described earlier in this section, we solicited and received many public comments regarding our proposed treatment of those items or services that are directly related to a surgical procedure and that would be paid separately under the OPPS but that were proposed for packaging under the revised ASC payment system. We address those specific comments and provide our responses below.

Comment: A number of commenters indicated that, if the goal of the revised ASC payment system is to create a payment system that is based on OPPS relative weights and payment rates, then the packaging policy for ASCs should be

based on the same inclusions as those found under the OPPS. They suggested that following the OPPS payment policies under the revised ASC payment system would promote parity in payments between HOPDs and ASCs and, thereby, eliminate inappropriate incentives to base care decisions on payment considerations. Specifically, a number of commenters were concerned about payment differences that could arise between HOPDs and ASCs when services outside the CPT surgical range were provided in an ASC in conjunction with a covered surgical procedure on the ASC list. They noted that when HOPDs provide some of these services and items, they generally receive separate payment for them.

Response: Because we received numerous comments on various issues related to the proposed packaging of payment for specific items and services under the revised ASC payment system where the proposed packaging policy differs from the OPPS payment policy, we address them separately in the following sections:

a. Radiology Services

Under the existing ASC payment system, we define a surgical procedure as any procedure described within the range of Category I CPT codes that the AMA defines as ''surgery'' (CPT codes 10000–69999). In the August 2006 proposed rule, we indicated that we would continue this standard (71 FR 49636). Because the HCPCS codes that describe radiology services are outside of the CPT surgical range, payment for radiology services that are directly related to surgical procedures has been packaged into the ASC payment for the covered surgical procedure under the existing ASC payment system. The current regulatory definition of an ASC does not allow the ASC and another entity to mix functions and operations in a common space during concurrent or overlapping hours of operation. That is, the two facilities must be separated by time (different hours of operation) or the other entity may operate in the ASC's space when the ASC is not operating in that space. Historically, we have made an exception to this rule when there is a need for imaging services during the course of a covered surgical procedure in progress in an ASC under the existing ASC payment system. In that case, an Independent Diagnostic Testing Facility (IDTF) sharing the space with the ASC (normally at a different time) may conduct the required radiology service outside of its normal business hours, as needed, and receive Medicare payment for those services. Specifically, under the existing ASC payment system if an ASC enrolls in the Medicare program as an IDTF and bills as that supplier when furnishing a radiology service that is reasonable and necessary and directly related to and furnished in conjunction with a covered surgical procedure, the IDTF may bill and receive payment under the MPFS for imaging and guidance services, even though they are being provided during the ASC's designated hours.

The GAO Report on ASC payment released on November 30, 2006 confirmed that separate payment is commonly made to another Part B supplier for these radiology services provided in association with surgical procedures in ASCs. Currently, radiology services provided in association with surgical procedures paid under the OPPS are either packaged or paid separately through an OPPS facility payment. We received a number of comments regarding our proposal to package payment for radiology services into payment for their associated surgical procedures under the revised ASC payment system. A summary of the comments and our responses follow.

Comment: Numerous commenters opposed CMS' proposed policy of packaging payment for radiology services directly related to a surgical procedure into the ASC payment for the associated covered surgical procedure. Some commenters requested that CMS continue to follow the existing practice regarding separate payment for radiology services provided in association with surgical procedures under the current ASC payment system. That is, they recommended that CMS permit continued separate payments for such radiology services to IDTFs if the ASCs are enrolled as IDTFs and bill for the services as that type of supplier. On the other hand, other commenters believed that ASC enrollment as an IDTF supplier was unnecessarily administratively burdensome for those ASCs that only are providing radiology services necessary for the safe provision of surgical procedures. These commenters requested that CMS adopt the OPPS payment policy for radiology services under the revised ASC payment system, which either provides separate payment or packages their payment into the OPPS payment for the surgical procedure associated with the radiology services. They indicated that following the OPPS payment policy under the revised ASC payment system would promote parity in payments between HOPDs and ASCs, especially because the relative payment weights used in both payment systems were linked. In contrast, MedPAC recommended that CMS address the potentially inconsistent payment policies by creating larger payment bundles under the OPPS, consistent with CMS' proposal to package payment for radiology services directly related to a surgical procedure under the revised ASC payment system.

Response: We believe that appropriate radiology services may be necessary for the safe performance of covered surgical procedures that are provided to Medicare beneficiaries in ASCs, and we realize that under the current system, payments for many of these services are made to other Part B suppliers even though the radiology services are integral to the surgical procedures provided by ASCs. We have come to believe that the most prudent method for providing accurate payment for the ancillary radiology services that are integral to, and required for the successful performance of, covered surgical procedures is to provide separate payment for certain radiology services under our final policy for the revised ASC payment system. Payment for the costs of radiology services that are separately paid under the OPPS is not included in the OPPS payment weights upon which the revised ASC payment system is based so, under our proposal, ASCs may not have received the most appropriate payment for the costs of these associated radiology services. We will, therefore, provide separate payment to ASCs for certain ancillary radiology services when they are integral to the performance of a covered surgical procedure billed by the ASC on the same day, provided that separate payment for the radiology service would be made under the OPPS.

We specify that a radiology service is integral to the performance of a covered surgical procedure if it is required for the successful performance of the surgery and is performed in the ASC immediately preceding, during, or immediately following the covered surgical procedure. Based on our analysis of the OPPS data, we believe that, in most cases, a radiology service that is separately payable under the OPPS that is performed in the ASC on the same day as a covered surgical procedure will be provided integral to a covered surgical procedure, and the ASC will be able to receive separate payment for the service as a covered ancillary service. The separate ASC payments for these radiology services will be made at the lower of: (1) The amount calculated according to the standard methodology of the revised ASC payment system; or (2) the MPFS nonfacility practice expense amount for the service (specifically, for the

technical component (TC) if the service's HCPCS code is assigned a TC under the MPFS). This is similar to our final payment policy for covered office-based surgical procedures added to the ASC list in CY 2008 or later years. Payment for the costs of the facility resources associated with the radiology service would have been made to IDTFs under the existing ASC payment system at the MPFS nonfacility practice expense amount. Therefore, we believe the revised payment system beginning January 1, 2008, will both ensure appropriate and equitable payment for covered ancillary radiology services integral to covered surgical procedures and not provide a payment incentive for migration of services from physicians' offices or IDTFs to ASCs.

This final policy will not encourage the proliferation of ASCs enrolling as IDTF suppliers, a practice which could lead to even greater future increases in the volume of diagnostic imaging services than those recently observed for such services to Medicare beneficiaries. CMS defines an IDTF in § 410.33 as an entity independent of a hospital or physician's office in which diagnostic tests are performed by licensed or certified nonphysician personnel under appropriate physician supervision. ASCs are distinct entities that operate exclusively for the purpose of providing surgical services to patients not requiring hospitalization (§ 416.2). As discussed earlier, an ASC that is also enrolled as an IDTF must maintain separate, exclusive hours of operation from those of the IDTF, and there may be no overlap in the hours of operation of the two entities.

In order to bill for diagnostic tests, the IDTF must be enrolled as such with Medicare and meet specific requirements regarding its structure, ownership and, operation as set forth in § 410.33. As stated in § 416.49, an ASC is responsible for obtaining radiologic services from a Medicare approved facility to meet the needs of its patients and, as confirmed by the GAO in its report released on November 30, 2006, many ASCs currently provide those radiology services in association with covered surgical procedures through other Part B suppliers, specifically IDTFs.

Under the revised payment system, there is no incentive for ASCs that provide only those radiology services that are integral to the performance of covered surgical procedures to also enroll as IDTFs. In contrast to current policy, under the revised system, payment will be made to the ASC for radiology services that are furnished integral to a covered surgical procedure. Payment will no longer be permitted to IDTFs for covered ancillary radiology services furnished integral to covered surgical procedures in ASCs. Because ASCs are distinct entities that operate exclusively to provide ambulatory surgical services, we would not expect that IDTFs sharing space with ASCs would be billing for any services for a patient receiving those services in an ASC on the date of a covered surgical procedure because all such services would be integral to the surgical procedure.

Under the final policy, only the ASC can receive payment for the facility resources required to provide the ancillary radiology services. IDTFs would not be able to bill for radiology services integral to the performance of a covered surgical procedure, an existing practice which commenters claimed is unnecessarily administratively burdensome because it requires ASCs that are only providing radiology services related to the safe performance of surgical procedures also to enroll as IDTF suppliers under Medicare. As of January 1, 2008, we are no longer permitting the exception that has allowed billing by IDTFs for required radiology services provided in ASCs during the course of covered ASC surgical procedures. We are also not allowing any other suppliers to bill for the technical component of radiology services provided in ASCs that are integral to the performance of an ASC covered surgical procedure. Only ASCs will receive separate payment for the technical component of those radiology services that are separately payable under the OPPS to ensure that no duplicate payment is made. This policy will ensure that packaged or separate payment is made to ASCs for all radiology services integral to the performance of covered surgical procedures, thereby providing appropriate payment to ASCs for those radiology services that are essential to the delivery of safe, high quality surgical care.

In summary, under the revised ASC payment system, we are adopting the OPPS payment status for radiology services and will pay separately, at the lower of the amount developed according to the standard methodology of the revised ASC payment system or the MPFS nonfacility practice expense amount, for ancillary radiology services designated as separately payable under the OPPS when those radiology services are integral to the performance of a covered surgical procedure provided on the same day and billed by the ASC. Similarly, we will package payment for those services that are designated as packaged under the OPPS into the payment for the covered surgical procedure. The separate national, unadjusted ASC payment for a covered ancillary radiology service would be based either upon the OPPS payment weight for the APC group of the radiology service, with application of the uniform ASC conversion factor, or upon the MPFS nonfacility practice expense relative value units (RVUs) for the service. Payment under the revised ASC payment system for these covered ancillary radiology services would be subject to geographic adjustment, like payment for covered surgical procedures. IDTFs would no longer be able to receive payment for ancillary radiology services that are integral to the performance of a covered surgical procedure for which the ASC is billing Medicare. This policy is consistent with the PPAC's request for uniform payment policies across the OPPS and the revised ASC payment system and is responsive to MedPAC's concern about creating different payment bundles for ASCs and HOPDs. Because the packaging status of radiology services under the revised ASC payment system will parallel their treatment under the OPPS, any changes to the packaging of radiology services under the OPPS that would alter the OPPS payment bundles would also occur under the revised ASC payment system. Therefore, we believe that this approach is fully consistent with the recommendations of MedPAC and the PPAC in applying payment policies consistently to both ASCs and HOPDs.

Radiology services include all Category I CPT codes in the radiology range established by CPT, from 70000 to 79999, and Category III CPT codes and Level II HCPCS codes that describe radiology services that crosswalk or are clinically similar to procedures in the radiology range established by CPT. This revised ASC payment system policy for each calendar year will apply to all radiology services that are separately payable under the OPPS in that same calendar year. An illustrative listing that includes all radiology services that are separately payable under the CY 2007 OPPS, which will be proposed for updating and then finalized in the CY 2008 OPPS/ASC proposed and final rules, respectively, can be found in Addendum BB to this final rule. Covered ancillary radiology services are assigned to payment indicator ''Z2'' (Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight) or ''Z3'' (Radiology service paid separately when provided integral to a

surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs). ASC payment rates for these radiology services will be determined according to the standard methodology of the revised ASC payment system as discussed further in section V. of this final rule, or according to the MPFS nonfacility practice expense amount, whichever payment amount is lower. This final policy is set forth in §§ 416.171(d) and 416.167(b)(3).

After consideration of all public comments received, we are finalizing a policy to provide separate payment under the revised ASC payment system for those ancillary radiology services separately paid under the OPPS that are integral to the performance of covered surgical procedures for which the ASC bills Medicare. This final policy contrasts with our proposal which would have provided packaged payment for all ancillary radiology services. Instead, under the revised ASC payment system, we will provide separate payment for those ancillary radiology services that are separately paid under the OPPS when they are provided on the same day as, and integral to, the performance of a covered surgical procedure in an ASC. Payment for ancillary radiology services that are packaged under the OPPS will be packaged under the revised ASC payment system, and these services are identified in Addendum BB to this final rule with payment indicator ''N1'' (Packaged service/item; no separate payment made).

Separately paid radiology services are considered to be covered ancillary services. ASC payment for these radiology services will not be subject to the 4-year transition (see section IV.J. of this final rule) because the services have never received separate payment under the existing ASC payment system. The 4-year transition applies only to those services that receive separate payment under the existing CY 2007 ASC payment system. We also are revising proposed § 416.164(a) and (b) to reflect this final policy.

b. Brachytherapy Sources

As we stated in the August 2006 proposed rule, under the existing ASC payment system, a single payment is made to an ASC for all facility services furnished by the ASC in connection with a covered surgical procedure. However, a number of services and related items covered under Medicare may be furnished in an ASC, where these items and services are not considered to be facility services and, therefore, are not paid through the ASC payment for the covered surgical procedure. These items and related services may be covered and paid to other Part B suppliers, such as physicians. Such is sometimes the case with payment for brachytherapy sources implanted in ASCs, where the needles and catheters to implant the sources are implanted during surgical procedures that are on the ASC list. Under the existing ASC payment system, while payment is not made for brachytherapy sources to ASCs, these sources may be separately paid at contractor-priced rates by Medicare contractors under the MPFS to physicians who may also be billing the CPT codes for application of the brachytherapy sources in ASCs. Contractor-priced rates are those payment rates for certain items or services that are individually established by each Medicare contractor for payment of claims submitted to them. Brachytherapy source application codes, which are included in the radiology section of the CPT code book, are not on the existing ASC list because they do not fall within the CPT surgical range and, therefore, are not defined as surgery for purposes of ASC payment. While we did not explicitly discuss payment for brachytherapy sources in the August 2006 proposed rule, we received a number of comments regarding payment for brachytherapy sources under the revised ASC payment system. A summary of the comments and our responses follow.

Comment: Several commenters suggested that CMS pay separately for brachytherapy sources under the revised ASC payment system when they are implanted in ASCs. Other commenters recommended that CMS continue to pay separately under the MPFS for brachytherapy sources provided in ASCs. The commenters requested that CMS allow separate payment for brachytherapy sources to facilitate the treatment of cancer patients who have brachytherapy sources implanted in ASCs. As an example, they described a closely related sequence of procedures performed in the ASC setting for the brachytherapy treatment of patients with prostate cancer, including the placement of needles and catheters, reported with a CPT code on the ASC list; the application of brachytherapy sources, reported with a CPT code not on the ASC list; and the provision of numerous brachytherapy sources, reported with specific Level II HCPCS codes in the OPPS setting. The commenters noted that it would be appropriate to implant brachytherapy sources in ASCs for the treatment of prostate cancer, because the surgical procedure to insert the required needles and catheters is currently on the ASC list and, in the case of prostate cancer in particular, patients must have the sources implanted in the same session where the needles or catheters are placed. The commenters pointed out that each of these related items and services is separately paid under the OPPS, so the base OPPS payment weights for the surgical needle and catheter placement procedures do not provide payment for the brachytherapy source application or the sources themselves. They noted that all of these individual procedures and items are required to provide the full brachytherapy treatment.

Response: Based on the comments received and our review of the issue, we have concluded that the most appropriate policy under the revised ASC payment system is to provide separate payment to ASCs for the brachytherapy sources as covered ancillary services implanted in conjunction with covered surgical procedures billed by ASCs. Further, as evidenced by our decisions regarding payment for other covered ancillary services under the CY 2008 revised ASC payment system, our intention is to maintain consistent payment and packaging policies across HOPD and ASC settings for covered ancillary services that are integral to covered surgical procedures performed in ASCs. Therefore, consistent with our policy to pay separately for some drugs, biologicals, and radiology services as covered ancillary services, we also believe that adopting a payment policy consistent with the OPPS for payment of brachytherapy sources is reasonable and appropriate to ensure that the comprehensive brachytherapy service can be provided by ASCs. The application of the brachytherapy sources is integrally related to the surgical procedures for insertion of brachytherapy needles and catheters, which are appropriate for performance in ASCs. There is a statutory requirement that the OPPS establish separate payment groups for brachytherapy sources related to their number, radioisotope, and radioactive intensity, as well as for stranded and non-stranded sources as of July 1, 2007, OPPS procedure payments do not include payment for brachytherapy sources. We agree with both MedPAC and the PPAC that consistent payment bundles between the two payment systems are desirable. Therefore, under the revised ASC payment system, we will pay ASCs separately for brachytherapy sources when they are provided in association with a surgical

procedure not excluded from ASC payment and billed by the ASC on the same day. The ASC brachytherapy source payment rate for a given calendar year will be the same as the OPPS payment rate for that year or, if specific OPPS prospective payment rates are unavailable, ASC payments for brachytherapy sources will be contractor-priced. The ASC brachytherapy source payment rate will be established at its OPPS payment rate, without application of the ASC budget neutrality adjustment factor to the OPPS conversion factor. In addition, consistent with the payment of brachytherapy sources under the OPPS, the ASC payment rates for brachytherapy sources will not be adjusted for geographic wage differences. Because brachytherapy sources are implantable devices with relatively fixed costs for which we would not expect efficiencies that would permit ASCs to acquire them at lower costs than HOPDs, we believe it is most appropriate to pay for the brachytherapy sources at the same rates as the OPPS if possible. A list of brachytherapy sources recognized under the CY 2007 OPPS, for which payment according to the statute is made at charges reduced to cost under the CY 2007 OPPS, is included in Table 3 below, as well as in Addendum BB to this final rule, specifically those codes assigned to payment indicator ''H7'' (Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced).

An updated list will be proposed and finalized for CY 2008 in the CY 2008 OPPS/ASC proposed and final rules, respectively, as will the CY 2008 OPPS payment rates for brachytherapy sources. We also may establish new brachytherapy source HCPCS codes, revise the existing HCPCS codes, or both, for separate payment on a quarterly basis under the revised ASC payment system, as we currently do under the OPPS, in order to keep the two payment systems aligned. In addition, we note that the CPT codes for the application of brachytherapy sources are radiology services in the radiology range of Category I CPT codes, so they would also be separately paid in ASCs under the revised ASC payment system if provided in association with a covered surgical procedure, as described in section IV.C.2.a. of this final rule.

TABLE 3.—BRACHYTHERAPY SOURCES PAID SEPARATELY UNDER THE CY 2007 OPPS AS OF APRIL 1, 2007

HCPCS code	Long descriptor
A9527	Iodine I–125, sodium iodide solution, therapeutic, per millicurie.
C1716	Brachytherapy source, Gold-198, per source.
C1717	Brachytherapy source, High Dose Rate Iridium-192, per source.
C1718	Brachytherapy source, Iodine-125, per source.
C1719	Brachytherapy source, Non-High Dose Rate Iridium-192, per source.
C1720	Brachytherapy source, Palladium-103, per source.
C2616	Brachytherapy source, Yttrium-90, per source.
C2633	Brachytherapy source, Cesium-131, per source.
C2634	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.
C2635	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.
C2636	Brachytherapy linear source, Palladium-103, per 1MM.
C2637	Brachytherapy source, Ytterbium-169, per source.

After consideration of all public comments received, we are finalizing a policy to provide separate payment under the revised ASC payment system for ancillary brachytherapy sources implanted in association with the performance of a covered surgical procedure that is billed by the ASC to Medicare. Under our proposal, no payment would have been made to ASCs for the implantation of brachytherapy sources in conjunction with covered surgical procedures, although payment could have been made to other Part B suppliers. Under this final policy, ASC payment for brachytherapy sources as covered ancillary services in a calendar year will be made at the OPPS rates for that same year, or if OPPS rates are unavailable, ASC payment will be made at contractor-priced rates. Payment rates for brachytherapy sources will not be developed through application of the uniform ASC conversion factor, and they will not be subject to the geographic adjustment. Accordingly, we are revising proposed § 416.164(a) and (b) to reflect this final policy.

We would also caution that we expect ASCs to follow all Federal, State, and local safety requirements regarding the proper handling and disposal of these radioactive substances. ASCs that cannot comply with those guidelines should not provide brachytherapy services. ASC policies for the proper handling and disposal of brachytherapy sources also should include accommodations for the appropriate disposal of sources that were not implanted.

c. Drugs and Biologicals

In the August 2006 proposed rule, we indicated that under the existing ASC payment system, payment for all drugs and biologicals (whether packaged or separately payable under the OPPS) is packaged into the ASC payment for the covered surgical procedure. We proposed to continue that policy under the revised ASC payment system. Under the OPPS, CMS pays separately for all pass-through drugs and biologicals, while nonpass-through drugs and biologicals are either packaged or paid separately under the OPPS, depending on whether or not their cost is equal to or less than $55 per day or exceeds $55 per day, respectively, for CY 2007. We received a number of comments on our proposal to package payment for all drugs and biologicals into the payment for their associated surgical procedures under the revised ASC payment system. A summary of the comments and our responses follow.

Comment: While the commenters generally agreed with CMS' proposal to package payment for inexpensive drugs into the ASC payment for the covered surgical procedure under the revised ASC payment system consistent with current practice, many commenters objected to CMS' proposed packaging of payment for expensive drugs and biologicals and urged CMS to pay separately for them. Moreover, several commenters requested that CMS adopt the OPPS payment policies for both pass-through and nonpass-through drugs and biologicals under the revised ASC payment system. They indicated that following the OPPS payment policies under the revised ASC payment system would promote parity in

payments between HOPDs and ASCs and, thereby, eliminate inappropriate incentives to base care decisions on payment considerations. Specifically, a number of commenters were concerned about payment differences that could arise between HOPDs and ASCs when items were provided in an ASC in conjunction with a covered surgical procedure on the ASC list. They noted that when HOPDs provide pass-through and many nonpass-through drugs and biologicals, they generally receive separate payment for these items; therefore, the base OPPS payment rates contain no payment for these drugs and biologicals.

Several commenters expressed particular concern regarding CMS' proposal to package payment for expensive biologicals into the associated surgical procedure's ASC payment. These commenters cited surgical procedures for the application of skin substitutes, newly proposed as additions for ASC payment in CY 2008, as examples of relatively inexpensive surgical procedures that require the use of costly biologicals, for which separate payment is made under the OPPS. They argued that the additions of the procedures to the ASC list would not provide meaningful access to those services in ASCs, given that the relatively low procedure payments proposed for the revised ASC payment system included no payment for those necessary biologicals. The commenters further added that not paying separately for expensive drugs and biologicals in ASCs could result in a shift of services from ASCs to HOPDs or physicians' offices, where they are separately paid, even though ASCs could be the most appropriate clinical setting for care. Some commenters suggested that CMS select specific drugs and biologicals for separate payment under the revised ASC payment system based on specific criteria such as their cost, required use, or association with specific surgical procedures not excluded from ASC payment.

Response: After considering all the comments related to payment for drugs and biologicals, we agree with the commenters that the revised ASC payment system should provide separate payment for relatively costly drugs and biologicals that are integral to covered surgical procedures that are billed by ASCs and whose payments are not packaged into the base OPPS payment rates. Therefore, effective January 1, 2008, we will pay separately for all OPPS pass-through and nonpass-through drugs and biologicals that are separately paid under the OPPS, when they are provided in association with a covered surgical procedure that is billed by the ASC to Medicare.

Based on the November 30, 2006 GAO Report on ASC payment, we recognize that historically common ASC procedures generally used drugs that are packaged under the OPPS, but we believe that the significant expansion of the procedures eligible for payment under the revised ASC payment system, in addition to evolving surgical practice, may necessitate the use of different drugs and biologicals in ASCs in the future. To ensure appropriate access to all surgical procedures that are safe for performance in ASCs, we believe it is prudent under the revised ASC payment system to provide separate payment in the ASC setting for drugs and biologicals that are integral to covered surgical procedures for which the ASC is billing, when the costs of those drugs and biologicals were not included in developing the base procedure payment weights under the OPPS. We do not believe it would be appropriate to select only a subset of these drugs and biologicals that are separately payable under the OPPS because we do not see a clear rationale for doing so.

We specify that a drug or biological is integral to the performance of a covered surgical procedure if it is required for the successful performance of the surgery and is provided in the ASC immediately preceding, during, or immediately following the covered surgical procedure. Based on our analysis of OPPS data, we believe that, in most cases, a drug or biological that is separately payable under the OPPS that is provided in an ASC on the same day as a covered surgical procedure will be provided as integral to the covered surgical procedure, and the ASC will be able to receive separate payment for the drug or biological as a covered ancillary service.

The payments for separately payable drugs and biologicals under the revised ASC payment system for a calendar year will be equal to the payment rates developed according to the payment methodology used in the OPPS for that same year, without the application of the ASC budget neutrality adjustment to the OPPS conversion factor. Because OPPS payment for separately paid drugs and biologicals is provided at the average hospital acquisition cost and is not based upon the application of the OPPS conversion factor to relative payment weights, we believe the OPPS rates should also reflect the typical acquisition cost of these products in the ASC facility setting as well. The OPPS currently relies on the average sales price (ASP) methodology to establish payment rates for many separately paid drugs and biologicals, and ASP data are based upon manufacturers' reports of all drug sales, including those to different types of facilities and physicians' offices. The ASP methodology is also utilized to establish the physician's office payment for drugs and biologicals. Therefore, we believe that aligning the ASC payment methodology with the OPPS payment for these covered ancillary services is a consistent and logical approach to setting their ASC payment rates, and we will not apply the ASC budget neutrality adjustment to establish the ASC payment rates. Comparable to their treatment under the OPPS, the ASC payment for separately paid drugs and biologicals will also not be subject to the geographic wage adjustment. In addition, ASC payment for drugs and biologicals that are not separately payable under the OPPS will be packaged into the payments for the covered surgical procedures with which they are administered, consistent with the current OPPS payment methodology.

As noted above, under the CY 2007 OPPS, payment for separately payable nonpass-through drugs and biologicals is made according to the ASP methodology, and is generally equal to the ASP plus 6 percent in CY 2007, the same as the physician's office payment. Payment for pass-through drugs and biologicals is set at the rate under the Competitive Acquisition Program (CAP) for Part B drugs or, if the drug is not included in the CAP, at the rate established by the ASP methodology and generally equal to the ASP plus 6 percent. A list of the drugs and biologicals that are separately paid under the CY 2007 OPPS, along with their payment rates as of April 1, 2007, is included in Addendum BB to this final rule, specifically those codes assigned to payment indicator ''K2'' (Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate). Drugs and biologicals for which payment is packaged under the CY 2007 OPPS are also listed in Addendum BB, where they are assigned to payment indicator ''N1'' (Packaged service/item; no separate payment made).

The CY 2008 payment status and payment rates for drugs and biologicals will be proposed and finalized in the CY 2008 OPPS/ASC proposed and final rules, respectively. We also may establish new HCPCS codes for separately payable drugs and plan to update payment rates for drugs and biologicals based on new ASP information on a quarterly basis under

the revised ASC payment system, as we currently do under the OPPS, in order to keep the two payment systems aligned. This final policy is consistent with the recommendation of the PPAC and the comments of MedPAC to align the payment bundles under the OPPS and ASC payment systems.

In summary, after consideration of all public comments received, we are finalizing a policy to provide separate payment under the revised ASC payment system for drugs and biologicals that are separately paid under the OPPS, when those items are integral to the performance of a covered surgical procedure for which the ASC is billing. We proposed to provide packaged payment for all drugs and biologicals under the revised ASC payment system through the ASC payment for the covered surgical procedure. In contrast, this final policy will provide separate payment for those drugs and biologicals that are separately paid under the OPPS, when those items are provided on the same day as and integral to the performance of a covered surgical procedure in an ASC. Separate ASC payment for these drugs and biologicals will be made at the OPPS payment rate for the same calendar quarter. ASC payment for those drugs and biologicals that are integral to the performance of a covered surgical procedure and whose payment is packaged under the OPPS will receive packaged payment under the revised ASC payment system. Payment rates for drugs and biologicals will not be developed through application of the uniform ASC conversion factor, and they will not be subject to the geographic adjustment. We also are revising proposed § 416.164(a) and (b) to reflect this final policy.

d. Implantable Devices With Pass-Through Status Under the OPPS

In the August 2006 proposal for the revised ASC payment system, we proposed to pay for all implantable devices as part of the ASC payment for the covered surgical procedure, thereby packaging payment for all devices except for the additional ASC adjustment for NTIOLs. Under this proposal, payment for devices included in those device categories with pass-through status under the OPPS would also be packaged. In contrast, pass-through status under the OPPS provides payment for a device included in the pass-through device category on a claim-specific basis at the hospital's charges reduced to cost. That is, fiscal intermediaries apply the hospital's overall cost-to-charge ratio from the hospital's last submitted cost report to the submitted charges on the claim and pay the resulting amount on a claim-specific basis. A device offset amount is applied, if appropriate, to take into consideration the predecessor device payment already packaged into the OPPS payment for the associated implantation procedure, in order to ensure no duplicate payment. The predecessor device is the device that would have been used in the procedure if the pass-through device had not been implanted and for which the historical cost is packaged into the payment for the implantation procedure.

Under the existing ASC payment system, payment for OPPS designated pass-through devices is either packaged into the ASC payment for the covered surgical procedure or, if the device is implantable DME or an implantable prosthetic, separately paid under the DMEPOS fee schedule, independent from the ASC payment for the associated surgical procedure. We received many comments regarding our proposal to package payment for devices with OPPS pass-through status into payment for their associated surgical procedures under the revised ASC payment system. A summary of the comments and our responses follow.

Comment: Many commenters encouraged us to expand the OPPS pass-through program to the revised ASC payment system, to provide separate payment for those devices whose payments, in whole or in part, were not packaged into the base OPPS payment weights upon which the revised ASC payment system would be based. These commenters questioned how ASCs would be paid appropriately for devices that are paid separately under the OPPS as pass-through devices at the hospital's charges reduced to cost by the hospital's overall cost-to-charge ratio. The commenters did not believe it would be appropriate to provide payment for devices with pass-through status under the OPPS packaged into the ASC payment for the associated surgical procedure, when there are either no costs associated with those devices packaged into the base OPPS procedure payment weights or inadequate costs associated only with predecessor devices packaged into the base OPPS weights.

The commenters added that many of the OPPS designated pass-through devices that are implanted in ASCs are expensive, and their cost would not be adequately reflected in the ASC payment for the covered surgical procedure. They believed that the proposed policy would result in little access to these new technologies in the ASC setting, despite the fact that the associated surgical procedures for their implantation are appropriate for ASC payment. They pointed out that only devices that demonstrate significant clinical improvement are provided pass-through status under the OPPS; hence, Medicare beneficiaries would be unable to receive the most clinically beneficial procedures in ASCs.

Several commenters requested that CMS not provide ASC payments for many surgical procedures that use implantable devices, generally for patient safety reasons, whether pass-through devices are used or not.

Response: While the OPPS pass-through program is a statutory requirement of the OPPS under section 1833(t)(6) of the Act and, therefore, not specifically applicable to the revised ASC payment system, we agree with commenters that similar device payment policies for these devices under the OPPS and the revised ASC payment system are most appropriate to ensure access to procedures implanting these clinically beneficial devices in ASCs. Specifically in the case of OPPS pass-through devices, the costs of the devices are not fully packaged into the OPPS payment weights upon which the revised ASC payment system is based because the devices are separately paid under the OPPS. We agree with commenters that if payments to ASCs for the associated surgical implantation procedures are inadequate to cover the costs of these beneficial devices, then ASCs will not offer the procedures implanting these devices and beneficiary access to these effective devices will thereby be limited to other sites for the services.

When we examined the three device categories that currently have pass-through status under the CY 2007 OPPS, specifically C1820 (Generator, neurostimulator (implantable), with rechargeable battery and charging system), C1821 (Interspinous process distraction device (implantable)), and L8690 (Auditory osseointegrated device, includes all internal and external components), we noted that the surgical procedures associated with both C1820 and L8690 are currently payable in the ASC setting. We continue to believe that the procedures associated with these pass-through device categories are safe for ASC performance and, as such, the procedures will be paid under the revised ASC payment system. We remind the public that the list of device categories with pass-through status under the OPPS is updated quarterly, with the addition of new pass-through device categories, if applicable, and that the dates for the expiration of pass-through payment for device categories

are proposed and finalized during the OPPS annual rulemaking cycle. Only device categories C1821 and L8690 will continue with pass-through status under the CY 2008 OPPS, but there may be additional device categories established in the future that will have pass-through status during all or a portion of that calendar year. Under the OPPS, claim-specific device pass-through payment is calculated based on the device charge reduced to cost by application of the overall hospital cost-to-charge ratio and, if applicable, the resulting device cost is further subject to a payment reduction (device offset) that is equivalent to the device cost for predecessor devices already included in the APC median cost for the associated surgical procedure. This ensures that the OPPS does not provide duplicate payment for any portion of an implanted device with pass-through status. Of the three device categories currently with pass-through status under the OPPS, only one device category (C1820) has an associated device offset due to the costs of the predecessor nonrechargeable implantable neurostimulators already packaged into the base APC payment weights for neurostimulator implantation procedures.

Commenters have persuaded us that, under the revised ASC payment system, it is appropriate to provide separate payment for devices that are included in device categories with pass-through status under the OPPS. A list of the OPPS pass-through device categories as of April 1, 2007 is provided in Table 4 below, and their HCPCS codes are also included in Addendum BB to this final rule, where they are assigned to payment indicator ''J7'' (OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced). Implantable devices that received packaged payment because they do not have OPPS pass-through status are also listed in Addendum BB to this final rule, where they are assigned to payment indicator ''N1'' (Packaged service/item; no separate payment made).

TABLE 4.—ACTIVE OPPS PASS-THROUGH DEVICE CATEGORIES UNDER THE CY 2007 OPPS AS OF APRIL 1, 2007

HCPCS code	Long descriptor
C1820	Generator, neurostimulator (implantable), with rechargeable battery and charging system.
C1821	Interspinous process distraction device (implantable).
L8690	Auditory osseointegrated device, includes all internal and external components.

It is not possible to pay for these devices using the specific OPPS payment methodology, because cost-to-charge ratios are not available for ASCs to convert ASC charges to cost in order to establish a claim-specific device payment. Because these devices are new technology and the number of device categories with pass-through status under the OPPS has been limited over the past several years, we believe that contractor-priced rates are the most appropriate payment methodology for these devices under the revised ASC payment system since there would be little or no OPPS claims data available to establish prospective payment rates for these devices. Therefore, we will pay ASCs separately for devices with pass-through status under the OPPS in that same quarter of the calendar year at contractor-priced rates when they are implanted in ASCs during a covered surgical procedure that is billed by the ASC. As under the OPPS, ASC payment for these devices would not be subject to the geographic wage adjustment, nor would the uniform ASC conversion factor be applied because there is no OPPS payment weight available for these devices and there is little clinical labor associated with the device acquisition by the ASC. The associated nondevice facility resources for the device implantation procedures would be paid through an ASC surgical procedure service payment based upon the payment weight for the nondevice portion of the related OPPS APC payment weight, as described further below with respect to ASC payment for implantable devices without pass-through status under the OPPS. This policy, similar to the device offset policy under the OPPS, would ensure no duplicate device payment by removing, if applicable, the costs of related predecessor devices packaged into the base procedure's OPPS payment weight. Under this policy, we will pay separately in ASCs for new devices that result in significant clinical improvement, consistent with the pass-through policy under the OPPS. This similar treatment of devices included in device categories with OPPS pass-through status under both the OPPS and revised ASC payment systems will help to ensure that beneficiaries have access to the devices in both settings. We believe this approach is fully consistent with the recommendation of the PPAC to apply payment policies uniformly to both ASCs and HOPDs, and with the comments of MedPAC in support of comparable payment bundles in the two systems.

As we have stated earlier in this final rule, we are firmly committed to ensuring that outpatient procedures are not limited to certain sites of service and that all surgical procedures that can safely be performed in ASCs and that are not expected to require an overnight stay are on the ASC list of covered surgical procedures so that Medicare beneficiaries have full access to surgical services in all appropriate settings. We believe that paying separately for those devices that are included in device categories with pass-through status under the OPPS and that are implanted during ASC covered surgical procedures under the revised ASC payment system will promote efficient resource use and ensure appropriate access to care.

After considering all public comments received, we are finalizing a policy to provide separate payment under the revised ASC payment system for ancillary devices included in device categories with pass-through status under the OPPS in the same quarter of the same calendar year that the devices are implanted during a covered surgical procedure that is billed by the ASC. In contrast with our proposal which would have provided packaged payment for these devices, but consistent with their separate payment under the OPPS, this specific subset of implantable devices will receive separate payment under the revised ASC payment system as covered ancillary services. ASC payment will be made for the devices at contractor-priced rates and will not be subject to geographic wage adjustment, and payment for the associated surgical procedures will be made according to our standard methodology for the revised ASC payment system, based on only the service (nondevice) portion of the procedure's OPPS relative payment weight. Accordingly, we are revising proposed § 416.164(a) and (b) to reflect this final policy.

e. Implantable Devices Without Pass-Through Status Under the OPPS

Historically, separate payment for implantable DME and prosthetics provided in association with procedures on the ASC list of covered surgical procedures has been made to ASCs on the basis of the DMEPOS fee schedule. Payment for other devices that are not implantable DME or prosthetics, including some nonpass-through devices under the OPPS, has historically been made as part of the ASC payment for the covered surgical procedure because such items have been considered to be supplies.

In the August 2006 proposed rule for the revised ASC payment system, we proposed to pay for nonpass-through devices as part of the ASC payment that would be based on the OPPS relative payment weight of the associated surgical procedure, thereby packaging payment for all nonpass-through devices, consistent with their treatment under the OPPS. We also proposed to apply an ASC budget neutrality adjustment of 62 percent to the OPPS conversion factor to calculate the ASC payment rates for all covered surgical services, regardless of the specific nature of the surgical procedures. Therefore, payment for surgical procedures with high device costs, referred to as device-intensive procedures, would be calculated like payment for all other surgical procedures not excluded from ASC payment under the revised payment system. We received many comments on our proposed payment policy for devices without pass-through status under the OPPS. A summary of the comments and our responses follow.

Comment: Many commenters objected to the packaging of payment for all devices as proposed, principally on the basis that, where the device cost exceeds 62 percent of the APC payment rate, the ASC would not be paid enough to cover the cost of the device, let alone the other service costs of the implantation procedure. Some commenters suggested that CMS continue to pay separately for devices for which it currently pays separately under the DMEPOS fee schedule and provide payment through the ASC payment for only the nondevice portion of the implantation procedure. They recommended that CMS apply the ASC conversion factor only to the nondevice portion of the APC payment weight to calculate the ASC service payment for the implantation procedure. Other commenters believed that CMS should not apply the ASC conversion factor to the device portion of the APC payment, but instead should pass the OPPS payment amount for the device through to the ASC payment system directly because ASCs would be unable to obtain the devices at lower cost than HOPDs. They argued that ASCs would see no efficiencies regarding the fixed device costs, so it would be inappropriate to apply the ASC conversion factor to develop this portion of the ASC procedure payment. These commenters suggested that CMS could then apply the ASC conversion factor to the nondevice portion of the APC payment to develop a service payment, and sum the two partial payments (for the device and the service) to calculate the full ASC payment for these device-intensive procedures under the revised ASC payment system. They concluded that, in this manner, the OPPS and the revised ASC payment system would be aligned, because both systems would provide packaged payment for devices without OPPS pass-through status.

Several commenters requested that CMS not provide ASC payments for many procedures that use devices and that are currently paid under the OPPS, generally for patient safety reasons.

Response: For purposes of the revised ASC payment system, we are defining device-intensive procedures as all those ASC covered surgical procedures in CY 2008 that are assigned to device-dependent APCs under the OPPS, where the APC device cost is greater than 50 percent of the median APC cost. There are 40 such procedures that fall into this group based on their CY 2007 APC assignments, 25 of which are on the CY 2007 ASC list and 15 of which will be newly recognized for ASC payment beginning in CY 2008. They are listed in Tables 5 and 6, respectively, below. These procedures are also identified in Addendum AA to this final rule.

Specific payment policies have been applied to device-dependent APCs under the OPPS over the past several years (71 FR 68063 through 68070). There are about 194 OPPS device-dependent procedures, specifically those procedures that are assigned to the 42 OPPS device-dependent APCs under the CY 2007 OPPS, and 89 of these device-dependent procedures are also paid in ASCs in CY 2007. However, only 25 of those 89 procedures are assigned to APCs that have device costs that exceed 50 percent of the APC median costs and would be subject to the payment policy applied to device-intensive procedures under the revised ASC payment system. Thus, as noted above, based on current data, there are 40 device-intensive surgical procedures for which ASC payment will be made in CY 2008. ASC payments for these 40 device-intensive procedures will be made according to the policy described for device-intensive ASC procedures based on their assignments to 19 of the 42 device-dependent APCs under the OPPS for CY 2007.

We do not agree with the commenters who believe that many device-intensive procedures are unsafe for performance in ASCs because most of these device-intensive procedures have been on the ASC list of covered surgical procedures for several years and no safety concerns have arisen. In the context of developing this final rule, we have once again reviewed the clinical characteristics of all of these device-intensive procedures based on the public comments and our final policies regarding surgical procedures for exclusion from ASC payment, as discussed in section III.A.2. of this final rule. We continue to believe that many device-intensive procedures are appropriate for performance in ASCs under the final policies of the revised ASC payment system.

We also are persuaded that it would be inappropriate to continue to provide separate payment for some implantable prosthetics and DME under the DMEPOS fee schedule by maintaining the practice of the existing ASC payment system. Payment for these devices is already packaged into the base OPPS payment weights, and separate payment for devices under the ASC payment system could essentially pay twice for the device. Separate payment for devices under the revised ASC payment system would also be contrary to MedPAC's support for our proposal to increase the size of the ASC payment bundles and to create comparable payable bundles under the OPPS and the revised ASC payment system. Most importantly, separate payment for certain devices would not provide the incentives for efficiency that would occur through packaging device payment into payment for the associated surgical implantation procedure, because increased packaging through larger payment bundles would encourage ASCs to provide surgical services as cost-effectively as possible. In addition, there are some expensive implantable devices, such as ICDs, which are not currently paid under the DMEPOS fee schedule, but for which we will provide payment for their associated surgical implantation procedures in ASCs beginning in CY 2008. If the separate DMEPOS payment methodology were to be continued, ASCs would be significantly underpaid for such procedures because the device would not be separately paid if it were neither implantable DME nor an implantable prosthetic device. The

commenters who recommended continued separate payment for some devices under the DMEPOS fee schedule provided no suggestions for developing the appropriate ASC payment for expensive implantable devices that are neither implantable DME nor implantable prosthetics.

We agree with the commenters who are concerned that our standard methodology for the revised ASC payment system that applies a uniform ASC conversion factor to the OPPS relative payment weights could provide inadequate payment for device-intensive procedures under the revised ASC payment system. The estimated budget neutrality adjustment for the revised ASC payment system was 62 percent of the OPPS conversion factor in the proposed rule, and it is currently 67 percent as discussed in section V. of this final rule (the final CY 2008 ASC budget neutrality adjustment will be proposed and finalized through the CY 2008 OPPS/ASC rulemaking cycle). Because of the expected magnitude of the difference between the estimated ASC procedure payments, calculated by application of the ASC conversion factor to the OPPS payment weights under the revised ASC payment system, and the OPPS payment rates for those same procedures, we are particularly concerned that under the revised ASC payment system device-intensive procedures would be underpaid if we paid for them as proposed.

We would not expect that ASCs' device costs for expensive devices would differ significantly from the device costs of HOPDs because we do not believe that ASCs would realize more substantial efficiencies in their acquisition of devices in comparison with HOPDs. On the other hand, we believe that ASCs would experience significant efficiencies in comparison with HOPDs when performing the implantation procedures themselves, consistent with the findings of the GAO Report regarding the lower cost of procedures in ASCs in comparison with HOPDs. These lower ASC costs may be attributable to a variety of factors, including lower facility overhead costs due to ASCs' limited operating hours, lack of emergency departments, specialization of ASCs contributing to efficient delivery of services, and the characteristics of different patient populations treated in ASCs versus HOPDs. Therefore, we believe it would be most appropriate under the revised ASC payment system to apply a modified payment methodology to this group of device-intensive services. Accordingly, in developing the ASC payment rates under the revised payment system for device-intensive procedures, we will calculate the device portion of the ASC procedure payment separately from the service portion, in order to provide special consideration for the packaged device costs that are unlikely to vary significantly across different facility settings.

Our final payment methodology for device-intensive procedures under the revised ASC payment system is as follows. We will apply the OPPS device offset percentage to the OPPS national unadjusted payment to acquire the device cost included in the OPPS payment rate for a device-intensive ASC covered surgical procedure, which we will then set as equal to the device portion of the national unadjusted ASC payment rate for the procedure. The device offset percentage, which is used under the OPPS to remove the predecessor device cost from the device pass-through payment when a pass-through device is paid at charges reduced to cost, so that the pass-through payment for the device only represents the incremental payment for the new device over the payment for predecessor devices already packaged into the APC payment is our best estimate of the amount of device cost included in an APC payment under the OPPS. We believe that use of the OPPS device offset percentage is appropriate to establish the device amount of payment when device-intensive procedures are furnished in an ASC under the revised ASC payment system. The OPPS device offset percentage is calculated for each OPPS device-dependent APC based upon the most recent year of hospital outpatient claims data available and represents the relative amount of device payment that we believe exists in the total APC payment. The device offset percentage is also applied to reduce the APC payment when a typically expensive device is provided to the hospital without cost or with full credit for the device being replaced and, therefore, the hospital incurs no device cost for implanting the replacement device. For more background on the calculation and use of the device offset percentage, we refer readers to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68077 through 68079).

We will then calculate the service portion of the ASC payment for device-intensive procedures by applying the uniform ASC conversion factor as specified in new § 416.171 to the service (nondevice) portion of the OPPS relative payment weight for the device-intensive procedure. Finally, we will sum the ASC device portion and ASC service portion to establish the full payment for the device-intensive procedure under the revised ASC payment system.

Tables 5 and 6 include the most current device-intensive procedures that would be subject to this modified payment methodology under the revised ASC payment system. The device-intensive procedure lists for the CY 2008 revised ASC payment system will be proposed and finalized in conjunction with the OPPS treatment of these procedures in the CY 2008 OPPS/ASC proposed and final rules, respectively. The device-intensive procedures in Tables 5 and 6 are listed in Addendum AA to this final rule, where they are assigned to payment indicators ''H8'' (Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate) and ''J8'' (Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate), respectively.

TABLE 5.—ILLUSTRATIVE LIST OF DEVICE-INTENSIVE PROCEDURES ON THE CY 2007 ASC LIST SUBJECT TO THE MODIFIED PAYMENT METHODOLOGY UNDER THE REVISED ASC PAYMENT SYSTEM BEGINNING IN CY 2008

HCPCS code	Short descriptor	CY 2007 OPPS APC	CY 2007 device-dependent APC offset percent
33212	Insertion of pulse generator	0090	74.74
33213	Insertion of pulse generator	0654	77.35
36566	Insert tunneled cv cath	0625	57.56
53445	Insert uro/ves nck sphincter	0386	61.16
53447	Remove/replace ur sphincter	0386	61.16
54401	Insert self-contd prosthesis	0386	61.16
54405	Insert multi-comp penis pros	0386	61.16
54410	Remove/replace penis prosth	0386	61.16

TABLE 5.—ILLUSTRATIVE LIST OF DEVICE-INTENSIVE PROCEDURES ON THE CY 2007 ASC LIST SUBJECT TO THE MODIFIED PAYMENT METHODOLOGY UNDER THE REVISED ASC PAYMENT SYSTEM BEGINNING IN CY 2008—Continued

HCPCS code	Short descriptor	CY 2007 OPPS APC	CY 2007 device-dependent APC offset percent
54416	Remv/repl penis contain pros	0386	61.16
55873	Cryoablate prostate	0674	53.78
61885	Insrt/redo neurostim 1 array	0039	78.85
61886	Implant neurostim arrays	0315	83.19
62361	Implant spine infusion pump	0227	80.27
62362	Implant spine infusion pump	0227	80.27
63650	Implant neuroelectrodes	0040	54.06
63685	Insrt/redo spine n generator	0222	77.65
64553	Implant neuroelectrodes	0225	79.04
64561	Implant neuroelectrodes	0040	54.06
64573	Implant neuroelectrodes	0225	79.04
64575	Implant neuroelectrodes	0061	60.06
64577	Implant neuroelectrodes	0061	60.06
64580	Implant neuroelectrodes	0061	60.06
64581	Implant neuroelectrodes	0061	60.06
64590	Insrt/redo pn/gastr stimul	0222	77.65
69930	Implant cochlear device	0259	84.61

TABLE 6.—ILLUSTRATIVE LIST OF DEVICE-INTENSIVE PROCEDURES NEW TO THE CY 2008 ASC LIST SUBJECT TO THE MODIFIED PAYMENT METHODOLOGY UNDER THE REVISED ASC PAYMENT SYSTEM BEGINNING IN CY 2008

HCPCS code	Short descriptor	CY 2007 OPPS APC	CY 2007 device-dependent APC offset percent
33206	Insertion of heart pacemaker	0089	77.11
33207	Insertion of heart pacemaker	0089	77.11
33208	Insertion of heart pacemaker	0655	76.59
33214	Upgrade of pacemaker system	0655	76.59
33224	Insert pacing lead & connect	0418	87.32
33225	Lventric pacing lead add-on	0418	87.32
33282	Implant pat-active ht record	0680	76.40
63655	Implant neuroelectrodes	0061	60.06
64555	Implant neuroelectrodes	0040	54.06
64560	Implant neuroelectrodes	0040	54.06
64565	Implant neuroelectrodes	0040	54.06
G0297	Insert single chamber/cd	0107	90.44
G0298	Insert dual chamber/cd	0107	90.44
G0299	Inser/repos single icd+leads	0108	89.40
G0300	Insert reposit lead dual+gen	0108	89.40

Table 7 provides an example of how we will calculate the ASC payment for a device-intensive procedure. We use the example of insertion of a cochlear implant, CPT code 69930 (Cochlear device implantation, with or without mastoidectomy), that is included in Table 5 above. For purposes of this illustration, we are using the CY 2007 OPPS/ASC final rule with comment period device offset percentage and payment rate for APC 0259 (Level VI ENT Procedures), the APC to which CPT code 69930 is assigned under the CY 2007 OPPS. We also assume that the ASC budget neutrality adjustment remains at 0.67 under both the first transition year and full implementation scenarios, yielding an ASC conversion factor of $42.543 based on our current estimate of the CY 2008 OPPS conversion factor. The example includes the estimated ASC payment in the first year of the 4-year transition and the estimated payment under full implementation of the revised ASC payment system.

TABLE 7.—EXAMPLE OF CALCULATION OF ASC PAYMENT FOR A DEVICE-INTENSIVE COVERED SURGICAL PROCEDURE ACCORDING TO THE MODIFIED PAYMENT METHODOLOGY OF THE REVISED ASC PAYMENT SYSTEM

	First year of 4-year transition	Full implementation of revised system
OPPS CY 2007 national unadjusted payment rate	$25,499.72	$25,499.72
OPPS CY 2007 device offset percent	84.61%	84.61%
OPPS/ASC device portion	$21,575.31 ($25,499.72 × 0.8461)	$21,575.31 ($25,499.72 × 0.8461)
OPPS service portion	$3,924.41	$3,924.41

TABLE 7.—EXAMPLE OF CALCULATION OF ASC PAYMENT FOR A DEVICE-INTENSIVE COVERED SURGICAL PROCEDURE ACCORDING TO THE MODIFIED PAYMENT METHODOLOGY OF THE REVISED ASC PAYMENT SYSTEM—Continued

	First year of 4-year transition	Full implementation of revised system
OPPS relative payment weight attributable to service (OPPS service portion divided by estimated CY 2008 OPPS conversion factor)	61.8047 ($3,924.41/63.497)	61.8047 ($3,924.41/63.497)
ASC service portion (OPPS relative payment weight for service portion multiplied by estimated CY 2008 ASC conversion factor)	$2,629.36 (61.8047 × $42.543)	$2,629.36 (61.8047 × $42.543)
CY 2007 ASC payment (without device payment)	$995	N/A
ASC service payment (see following paragraph)	$1,403.59 (0.25 × $2,629.36) + (0.75 × $995)	$2,629.36
Estimated CY 2008 ASC total payment (sum of service payment and device payment)	$22,978.90 ($1,403.59 + $21,575.31)	$24,204.67 ($2,629.36 + $21,575.31)

As discussed further in section IV.J. of this final rule and as shown in the example above, we will apply the transitional blend only to the service portion of the ASC procedure payment. Consistent with their treatment under the OPPS, we will apply the ASC geographic wage adjustment to payment for device-intensive procedures under the revised ASC payment system.

Comment: Several commenters encouraged CMS to pay the same amount and apply the same payment policies regarding implantable devices in both ASCs and HOPDs. In particular, they recommended that ASCs be paid 100 percent of the portion of the OPPS procedure payment that is device-related, when ASCs perform device-intensive procedures.

Response: We agree with commenters that providing the same device payment amount for expensive devices under the revised ASC payment system as under the OPPS is appropriate, and our final payment methodology accomplishes that. As we discuss above, we will specifically calculate the amount of OPPS device payment in APCs that contain devices for which the device cost exceeds 50 percent of the APC median cost. We will then add the OPPS device payment amount to the ASC service payment for each device-intensive procedure that is a covered ASC surgical procedure, in order to determine the total payment for the device-intensive procedure when it is performed in an ASC.

We also agree that the same payment policies that exist with regard to payment for costly devices under the OPPS should also apply to payment for devices implanted in ASCs. In particular, under the OPPS, beginning on January 1, 2007, when a device is replaced without cost to the hospital or with full credit for the cost of the device being replaced, CMS reduces the APC payment to the hospital by the amount that we estimate represents the cost of the device. The application of this same policy to ASC payment for certain device-intensive procedures is fully consistent with the comments that CMS should pay ASCs for expensive devices in the same manner that they are paid under the OPPS, and with the recommendation of the PPAC that CMS should apply payment policies uniformly under the OPPS and revised ASC payment systems. Therefore, in accordance with the OPPS policy implemented in CY 2007, beginning in CY 2008, we will reduce the amount of payment made to ASCs for device-intensive procedures assigned to certain OPPS APCs in those cases in which the necessary device is furnished without cost to the ASC or the beneficiary, or with a full credit for the cost of the device being replaced. We will provide the same amount of payment reduction that would apply under the OPPS for performance of those procedures under the same circumstances. Specifically, when an ASC performs a procedure that is listed in Table 8 below and the case involves implantation of a no cost or full credit device listed in Table 9, the ASC must report the HCPCS ''FB'' modifier on the line with the covered surgical procedure code to indicate that a major implantable device in Table 9 was furnished without cost. We expect that this scenario will occur most often in cases in which there is a recall, field action, or other activity that results in the ASC receiving a device from a device manufacturer, for which the facility has no obligation to pay. In these cases, this policy is necessary to be consistent with section 1862(a)(2) of the Act, which excludes from Medicare coverage items and services for which neither the beneficiary nor anyone on the beneficiary's behalf has an obligation to pay. This reduction policy is consistent with the modified payment methodology for device-intensive procedures under the revised ASC payment system that would generally provide the same device-related payment amount in HOPD and ASC settings, both in those cases where the facility bears the cost of the device and those situations where it does not. Tables 8 and 9 list those specific procedures and implantable devices to which the reduction policy applies under the CY 2007 OPPS. The list of device-dependent APCs and their associated procedures and implantable devices to which this policy will apply in CY 2008 will be proposed and finalized in the CY 2008 OPPS/ASC proposed and final rules, respectively. See the CY 2007 OPPS/ASC final rule with comment period (71 FR 68071 through 68077) for further discussion of this policy.

When the ''FB'' modifier is reported with a procedure code that is listed in Table 8, the contractor will reduce the ASC payment for the procedure by the amount of payment that CMS attributed to the device when the ASC payment rate was calculated. The reduction of ASC payment in this circumstance is necessary to pay appropriately for the covered surgical procedure being furnished by the ASC.

TABLE 8.—ILLUSTRATIVE LIST OF ADJUSTMENTS TO PAYMENTS FOR ASC COVERED SURGICAL PROCEDURES IN CY 2008 IN CASES OF DEVICES REPORTED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED

HCPCS code	Short descriptor	CY 2007 OPPS APC	APC group title	CY 2007 OPPS offset percent
61885	Insrt/redo neurostim 1 array	0039	Level I Implantation of Neurostimulator	78.85
63650	Implant neuroelectrodes	0040	Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	54.06
64555	Implant neuroelectrodes.			
64560	Implant neuroelectrodes.			
64561	Implant neuroelectrodes.			
64565	Implant neuroelectrodes.			
63655	Implant neuroelectrodes	0061	Laminectomy or Incision for Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve.	60.06
64575	Implant neuroelectrodes.			
64577	Implant neuroelectrodes.			
64580	Implant neuroelectrodes.			
64581	Implant neuroelectrodes.			
33206	Insertion of heart pacemaker	089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	77.11
33207	Insertion of heart pacemaker.			
33212	Insertion of pulse generator	0090	Insertion/Replacement of Pacemaker Pulse Generator.	74.74
33210	Insertion of heart electrode	0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	41.88
33211	Insertion of heart electrode.			
33216	Insert lead pace-defib, one.			
33217	Insert lead pace-defib, dual.			
G0297	Insert single chamber/cd	0107	Insertion of Cardioverter-Defibrillator	90.44
G0298	Insert dual chamber/cd.			
G0299	Inser/repos single icd+leads	0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	89.40
G0300	Insert reposit lead dual+gen.			
63685	Insrt/redo spine n generator	0222	Implantation of Neurological Device	77.65
64590	Insrt/redo perph n generator.			
64553	Implant neuroelectrodes	0225	Implantation of Neurostimulator Electrodes, Cranial Nerve.	79.04
64573	Implant neuroelectrodes.			
62361	Implant spine infusion pump	0227	Implantation of Drug Infusion Device	80.27
62362	Implant spine infusion pump.			
69930	Implant cochlear device	0259	Level VI ENT Procedures	84.61
61886	Implant neurostim arrays	0315	Level II Implantation of Neurostimulator	83.19
53440	Male sling procedure	0385	Level I Prosthetic Urological Procedures	46.86
53444	Insert tandem cuff.			
54400	Insert semi-rigid prosthesis.			
53445	Insert uro/ves nck sphincter	0386	Level II Prosthetic Urological Procedures	61.16
53447	Remove/replace ur sphincter.			
54401	Insert self-contd prosthesis.			
54405	Insert multi-comp penis pros.			
54410	Remove/replace penis prosth.			
54416	Remv/repl penis contain pros.			
33224	Insert pacing lead & connect	0418	Insertion of Left Ventricular Pacing Elect	87.32
33225	L ventric pacing lead add-on.			
33213	Insertion of pulse generator	0654	Insertion/Replacement of a permanent dual chamber pacemaker.	77.35
33214	Upgrade of pacemaker system	0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	76.59
33208	Insertion of heart pacemaker.			
33282	Implant pat-active ht record	0680	Insertion of Patient Activated Event Recorders.	76.40

TABLE 9.—ILLUSTRATIVE LIST OF DEVICES FOR WHICH THE ''FB'' MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED

Device	Short descriptor
C1721	AICD, dual chamber.
C1722	AICD, single chamber.
C1764	Event recorder, cardiac.
C1767	Generator, neurostim, imp.
C1771	Rep dev, urinary, w/sling.
C1772	Infusion pump, programmable.
C1776	Joint device (implantable.
C1777	Lead, AICD, endo single coil.

TABLE 9.—ILLUSTRATIVE LIST OF DEVICES FOR WHICH THE ''FB'' MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED—Continued

Device	Short descriptor
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.

TABLE 9.—ILLUSTRATIVE LIST OF DEVICES FOR WHICH THE ''FB'' MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED—Continued

Device	Short descriptor
C1882	AICD, other than sing/dual.
C1891	Infusion pump, non-prog, perm.
C1895	Lead, AICD, endo dual coil.
C1896	Lead, AICD, non sing/dual.
C1897	Lead, neurostim, test kit.
C1898	Lead, pmkr, other than trans.
C1899	Lead, pmkr/AICD combination.

TABLE 9.—ILLUSTRATIVE LIST OF DEVICES FOR WHICH THE ''FB'' MODIFIER MUST BE REPORTED WITH THE PROCEDURE CODE WHEN FURNISHED WITHOUT COST OR FOR WHICH FULL CREDIT IS RECEIVED—Continued

Device	Short descriptor
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.

After considering all public comments received, while we are finalizing our proposed policy to package payment under the revised ASC payment system for all implantable devices without pass-through status under the OPPS into the ASC payment for the associated surgical implantation procedure, we are adopting a modified methodology to calculate the payment rates for device-intensive procedures under the revised ASC payment system. We proposed to pay for these devices and their associated implantation procedures according to the standard revised ASC payment system methodology, with application of the uniform ASC conversion factor to the applicable OPPS payment weight for the procedure. However, our final payment policy will apply a modified payment methodology to develop the ASC payment rates for device-intensive covered surgical procedures, in order to provide the same payment amount to ASCs for the implantable devices as is made under the OPPS. This methodology will apply to ASC covered surgical procedures that are assigned to device-dependent APCs under the OPPS for the same calendar year, where those APCs have a device cost of greater than 50 percent of the APC cost (device offset percentage greater than 50). While lists of device-intensive procedures under the revised ASC payment system to which this policy would apply based on their CY 2007 OPPS status are included in Tables 5 and 6 of this final rule, the list of ASC procedures subject to this modified payment methodology will be proposed and finalized in the CY 2008 OPPS/ASC proposed and final rules, respectively.

We will also reduce the ASC procedure payment for certain device-intensive procedures when the necessary device is furnished to the ASC or the beneficiary at no cost or when a full credit for the device being replaced is provided to the ASC, by the same amount as the OPPS payment reduction for the same calendar year because neither the HOPD nor the ASC incur a device cost for the replaced device in such situations. Accordingly, we are adding new § 416.179 to reflect this payment reduction policy.

D. Payment for Corneal Tissue Under the Revised ASC Payment System

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 coinsurance and deductible requirements, and could be paid as an add-on to either the ASC payment 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 corneal 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 summarized 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 acquisition 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 (now MACs) to make separate payment for the costs incurred to procure corneal tissue for transplant at an ASC.

In the August 2006 proposed rule to revise the ASC ratesetting methodology and payment rates beginning in CY 2008, we proposed to continue to pay ASCs separately, based on their invoiced costs, for the procurement of corneal tissue (71 FR 49648). We had 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. We noted that, if we were to package payment for the procurement of corneal tissue into the APC payment for corneal transplant procedures, we believed the resulting payment rate would 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. We further proposed in the August 2006 proposed rule to exclude, through proposed new § 416.164(b), the costs of procurement of corneal tissue furnished in an ASC on or after January 1, 2008 from the scope of ASC facility services.

We invited comments and submission of data that supported or challenged this proposal to continue paying ASCs separately for corneal tissue on an acquisition cost basis.

Comment: Several commenters agreed with our proposal to continue to pay separately for the acquisition costs of corneal tissue under the revised ASC payment system, rather than package payment for corneal tissue costs into the payment for the associated corneal transplant procedure. The commenters indicated that this proposed methodology is consistent with the way physicians and HOPDs are currently paid for corneal tissue procurement. They believed that this policy of paying separately for the procurement of corneal tissue has been, and continues to be, the most appropriate payment policy for these services provided in ASC settings, because of the continuing significant variability in the costs of corneal tissue procurement. The commenters further reiterated that packaging these costs should not be considered, because such an option would result in overpayments to certain facilities that have been able to acquire corneal tissue at little or no cost through philanthropic organizations and would undoubtedly result in underpayments to other facilities that paid for the corneal tissue processing, testing, preservation, and transportation costs.

Response: After consideration of the public comments we received, we are finalizing our proposed CY 2008 ASC corneal tissue procurement payment policy, with modification to clarify that

corneal tissue is a covered ancillary service within the scope of ASC services, but not within the scope of ASC facility services. Corneal tissue procurement will be included in the scope of ASC services as a covered ancillary service when it is integral to the performance of an ASC covered surgical procedure, but its payment will not be packaged into the ASC payment for the associated covered surgical procedure. Specifically, under the revised ASC payment system, we will continue to pay ASCs separately, based on their invoiced costs, for the acquisition costs of corneal tissue for transplant in an ASC. The HCPCS code for corneal tissue processing, V2785, is listed in Addendum BB to this final rule, where it is assigned to payment indicator ''F4'' (Corneal tissue processing; paid at reasonable cost). Accordingly, we are reflecting this final policy in revised proposed §§ 416.164(b)(3) and 416.171(b).

E. Payment for Office-Based Procedures

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 of covered surgical procedures. 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 of covered surgical procedures 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 have argued 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 in an ASC or a hospital. Representatives of the ASC industry have contended that unless we made an exception to the criteria that historically governed which procedures comprised the ASC list and allowed 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 asserted in the past that this limitation was 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 the August 2006 proposed rule for the revised ASC payment system and as discussed in section III.A.2. of this final rule, we proposed to expand the ASC list of covered surgical procedures to allow payment for all surgical procedures, except those procedures that pose a significant safety risk or would be expected to 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 proposed not to exclude them from ASC payment under the revised ASC payment system. However, we were concerned that allowing payment to ASCs 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 which we proposed not to exclude from ASC payment beginning in CY 2008 are office-based, that is, they are performed in the physician's office more than 50 percent of the time. The practice expense payment for many of these procedures under the MPFS, when they are performed in the physician's office, would be lower than the payment for the same procedures under the OPPS or under the standard methodology of the revised ASC payment system as proposed. Therefore, we indicated that the proposed ASC payment rates based on the OPPS relative payment weights could result in a significant program cost if these high volume procedures were to shift from the office-based setting to the ASC setting.

One reason why we were concerned about the possibility of a sizable shift of office-based procedures to ASCs is the impact that such a shift might 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 that would be made if the revised payment system were not implemented. In the August 2006 proposed rule, we explained that, depending on the methodology for determining the requisite budget neutrality adjustment (71 FR 49657), an influx of high-volume, relatively low cost office-based surgical procedures into the ASC setting under the revised payment system could lower the payment amounts for other procedures made to ASCs due to the constraints of budget neutrality. In other words, we might have had 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 revised 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-based procedures shifting to ASCs. (See section V. of this final rule for a detailed discussion of our proposed and final policies regarding calculation of an ASC conversion factor.)

In the August 2006 proposed rule, we explained that 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 properly be based on clinical considerations. Towards that end, we proposed to cap payment for office-based surgical procedures for which ASC payment would be newly allowed under the revised payment system as of January 1, 2008, at the lesser of the MPFS nonfacility practice expense amount or the ASC rate developed according to the standard methodology of the revised ASC payment system. We also proposed to exempt procedures that are on the ASC list as of January 1, 2007, and that meet our criterion for designation as office-based, from the payment limitation proposed for office-based procedures for which ASC payment would be allowed for the first time beginning January 1, 2008. Accordingly, we proposed to incorporate in proposed new § 416.171(e) the payment basis for these office-based procedures beginning January 1, 2008.

When we started to identify the codes that we would propose to classify as office-based surgical procedures 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 met the 50-percent office utilization threshold but for which a nonfacility practice expense amount had not been developed under the MPFS. We proposed to classify as office-based any surgical codes that our physicians' claims data indicated are performed more than 50 percent of the time in an office setting, even if the codes currently lack a nonfacility practice expense value under the MPFS. We further proposed to cap payment for these procedures, as appropriate, once a nonfacility practice expense amount is established. Until that time, we proposed to calculate payment for these office-based surgical CPT codes using the methodology we proposed for other surgical procedures under the revised ASC payment system. Similarly, until a national nonfacility practice expense amount is established for office-based surgical CPT codes that are contractor-priced (that is, carriers typically determine the payment for a procedure for which there is no calculated national payment) under the MPFS, we proposed to calculate the ASC payment using the same methodology that we proposed 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 OPPS/ASC payment update.

In applying the 50-percent threshold, we discovered some apparent contradictions in the BESS data that required us to further refine our definition of office-based procedures. For example, we noted instances in which seemingly similar procedures had inconsistent site-of-service utilization data. The BESS data showed high levels of office utilization for some complex procedures that we expected to be performed relatively infrequently in an office setting, whereas simpler but related procedures showed lower levels of office utilization.

Therefore, we undertook another, more detailed level of review and identified groups of surgical CPT 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; 1.1 cm 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's 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, it would seem that the less complex procedures would also have been performed frequently in that site of service. However, the BESS data showed that this was not always the case.

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 were instances in which the less complex procedures within the code group were billed more commonly in an ASC or HOPD, while the more complex procedures within the code group were billed more frequently in the office setting. Therefore, we believed it was prudent to consider the clinical characteristics and utilization data of related CPT codes in determining the codes to be proposed as office-based, to supplement our consideration of data specific to the codes under review.

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's office. However, closer inspection revealed that there was only one case reported for the procedure with a physician's office as the site of service. We were concerned about using such a low volume of procedure claims as the basis for identifying a procedure as office-based. Therefore, we also believed it was wise to consider the volume of claims for procedures in the context of our assessment of their utilization data, to determine those codes to propose as office-based for the revised ASC payment system.

Because of the occasional unevenness and inconsistency 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, in our proposed rule, there were some procedures that met the 50-percent office performance threshold when evaluated in isolation from other closely related codes, but that we did not propose to designate as office-based after more specific review.

In the August 2006 proposed rule for the revised ASC payment system, we proposed to assess each year, based on the most recent available BESS and other data available to us and detailed clinical review, whether there are additional procedures that we would propose to newly classify as office-based, beginning in the update year. We would solicit comments on the proposed classification of additional codes as office-based as part of the annual OPPS/ASC rulemaking cycle. In addition, we proposed that once we identify a procedure as office-based, that classification could not change in future updates of the ASC payment system. We reasoned 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 proposed as office-based took into account the most recent available volume and utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. We proposed to apply the office-based designation only to procedures that would no longer be excluded from ASC payment beginning in CY 2008 or later years. Moreover, we proposed to exempt all procedures on the CY 2007 ASC list from application of the office-based classification. We believed that the resulting list accurately reflected Medicare practice patterns and was clinically coherent. The procedures that we proposed to designate as subject to the office-based payment limit were identified in Addendum BB to the proposed rule (71 FR 49845 through 49948). Those procedures for which the CY 2008 payment would be based on the MPFS nonfacility practice expense RVUs according to our analysis for the August 2006 proposed rule were flagged in Addendum BB to that rule. The ASC relative payment weights shown for procedures in Addendum BB to the proposed rule that would be capped by the MPFS nonfacility practice expense RVUs were adjusted to reflect the capped payment amounts. We reminded readers in the August 2006 proposed rule that the ASC payment rates in

Addendum BB to that rule were based on the proposed CY 2007 OPPS relative payment weights and the proposed CY 2007 MPFS nonfacility practice expense RVUs. Similarly, the information in Addenda AA and BB to this final rule is also only illustrative, meaning that the Addenda provide examples of the results of applying the final policies of the revised ASC payment system, based on the final information available for CY 2007 and projected CY 2008 updates. As further discussed in sections V.E. and VI. of this final rule, we will propose the CY 2008 relative payment weights, payment amounts, specific HCPCS codes to which the final policies of the revised ASC payment system would apply, and other pertinent ratesetting information for the CY 2008 revised ASC payment system in the proposed OPPS/ASC rule to update the payment systems for CY 2008 to be issued in mid-summer of CY 2007. We will then publish final relative payment weights, payment amounts, specific CY 2008 HCPCS codes to which the final policies will apply, and other pertinent ratesetting information for the CY 2008 revised ASC payment system in the final OPPS/ASC rule to update the payment systems for CY 2008.

Comment: Several commenters suggested that instituting a cap on payment for office-based surgical procedures would result in payment levels that would make it economically infeasible for many ASCs to perform certain surgical procedures, forcing patients who could be treated safely and more cost effectively in an ASC to go to an HOPD for surgery. Other commenters suggested that there is no empirical evidence that payment of office-based procedures in ASCs would lead to overutilization of ASCs or result in physicians converting their offices into ASCs. The commenters pointed out that, in historical cases where CMS has made exceptions to allow ASC payment for procedures primarily performed in the office, there have not been significant shifts in the sites of service for these procedures. Several commenters suggested that imposing a cap on payment for these procedures would be tantamount to a penalty and an affirmative policy intended to discourage these procedures from performance in the ASC setting. The commenters strongly recommended that the best policy would be to allow physicians to select the site of service they believe is the most clinically appropriate for their patients, especially because sicker patients may require the additional infrastructure and safeguards of an ASC or a HOPD. Other commenters pointed out that CMS' proposal for the revised ASC payment system depends on the use of the relative payment weights for the OPPS that CMS argued in the proposed rule would be expected to reasonably reflect the relativity of ASC resources for surgical procedures. They stated that CMS has no evidence to suggest that the OPPS relativity of payment weights for office-based procedures does not reflect the relative resource use for the performance of these procedures in ASCs and, therefore, application of a payment limitation for these procedures is unwarranted.

The commenters also expressed concern that the establishment of a payment cap for office-based procedures would be problematic and detrimental to CMS' desire to create a setting-neutral payment system. The commenters recommended that CMS exclude this provision from the final rule and pay all procedures using a single ASC conversion factor applied to the applicable OPPS relative payment weight. Several commenters suggested that CMS could follow trends in the sites of service for office-based procedures, and should CMS find significant and unwarranted migration of certain procedures to ASCs, implement the proposed policy at a later date.

Response: We acknowledge the commenters' concerns regarding our proposal to cap payments for office-based surgical procedures performed in ASCs. Nevertheless, we continue to believe that capping the payment for office-based surgical procedures performed in ASCs would be the best approach to eliminating differential payment as a factor in site-of-service decisions regarding minor surgical procedures. The combined ASC and physician payment exceeds the single payment the physician would receive for services performed in the office, even with the application of the proposed payment limitation for office-based procedures. Therefore, we are concerned 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. As discussed further in section V. of this final rule, the final policy for the budget neutrality adjustment for the revised ASC payment system which would cap payment for office-based surgical procedures as we proposed takes into account the expected migration of 15 percent of the current office utilization of office-based procedures that will be newly paid in CY 2008 under the revised ASC payment system over the first 4 years of the revised payment system. As commenters observed, a setting-neutral payment system is most consistent with the principle that physicians should be free to make site-of-service decisions on the basis of clinical and quality of care considerations alone. We strongly agree that the health of the patient should be the primary consideration. The proposed cap significantly reduces the payment differential that would otherwise exist when office-based surgical procedures are performed in ASCs and is, thus, more consistent with the principle of site-neutral payment.

After consideration of the public comments we received, we are finalizing our proposal under § 416.167(b)(3) and § 416.171(d), without modification, to cap payment for office-based surgical procedures for which ASC payment would first be allowed under the revised payment system beginning in January 1, 2008, or later years at the lesser of the MPFS nonfacility practice expense amount or the ASC rate developed according to the standard methodology of the revised ASC payment system. For those office-based procedures for which there is no available MPFS nonfacility practice expense amount, we will implement the cap, as appropriate, once a MPFS nonfacility practice expense amount is available. Until that time, those procedures that are office-based but for which there is no available MPFS nonfacility practice expense amount available for the comparison will be paid using the standard methodology for calculating ASC payment under the revised ASC payment system.

The procedures that we are finalizing as office-based for CY 2008 are identified in Addendum AA to this final rule, assigned to payment indicators of ''P2'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight); ''P3'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs); and ''R2'' (Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight). These payment indicators identify the office-based procedures' estimated payment status under the CY 2008 revised ASC payment system, based on the final CY 2007 information for the OPPS and the MPFS as discussed above, and their illustrative CY 2008 relative payment weights and payment rates reflect

application of the capped payment amounts for those procedures with a payment status indicator of ''P3.'' We note that the actual proposed and final ASC relative payment weights and payment amounts for CY 2008 will be proposed and finalized through the CY 2008 OPPS/ASC proposed and final rules, respectively. We will continue to monitor the appropriateness of the payment cap for office-based surgical procedures performed in ASCs and explore other opportunities to promote site-neutral payments as we gain experience under the revised ASC payment system.

Comment: Several commenters expressed concern about the ''50-percent rule'' we proposed to use to designate which procedures would be considered office-based. One commenter indicated that if a procedure is performed in an office 50 percent of the time, that means half the time the physician has determined that the office is not the appropriate setting for specific patients. Commenters further indicated that clinical circumstances dictate the site of service and not the physician's personal preference, as suggested by the policy proposed for the revised payment system. One commenter stated that surgeons often perform a procedure in the office when anesthesia is not required and perform the same procedure in an ASC when anesthesia is required due to the complexity of individual patient factors.

The commenters offered several suggestions for modifying the specific proposal for designating procedures as office-based. In particular, one commenter requested that there be a reasonable, fair, and efficient mechanism for removing a procedure from the office-based list if the typical site of service for a procedure does change for a legitimate clinical reason. Other commenters recommended that CMS consider raising the threshold above 50 percent to a number that shows the clear majority of cases are performed in the physician's office or allow an exemption to the cap for procedures that are performed in ASCs because of the need for anesthesia. Another commenter suggested that CMS could implement this policy through the use of a modifier that indicates the surgeon selected the ASC over the physician's office as the site of service because of the necessity of anesthesia or patient factors, whereupon the payment limitation would not be applied.

Response: As indicated in our proposed rule, office-based procedures are surgical procedures that the most recent BESS data available indicate are performed more than 50 percent of the time in the physician's office setting. We believe our ''50-percent rule'' proposed policy is the best option at this point in time. It is our current practice to consider procedures that are performed more than 50 percent of the time in the physician's office setting as office-based procedures, and we will continue to monitor whether the 50-percent threshold is appropriate for this categorization. These office-based procedures, as categorized through application of the ''50-percent rule,'' are typically procedures that have transitioned from low volume in the office setting and high volume in the facility setting to higher volume in the office setting and lower volume in the facility setting. The 50-percent threshold marks the point in that transition at which a procedure comes to be performed more often in the office. Typically, procedures that come to be performed more frequently in offices than in the facility setting remain primarily office-based once that transition has taken place. Therefore, we continue to believe that the 50-percent threshold is an appropriate, objective measure for determining which procedures ought to be considered office-based. Moreover, a rigorous review of procedures that met the aforementioned threshold took 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. In addition, we conducted a code-by-code analysis to bolster inconclusive data with the clinical judgment of our medical advisors.

We will continue 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. However, we note that we proposed that once we identify a procedure as office-based, that classification would not change in future updates of the ASC payment system, except in cases of new codes, where those initial determinations are temporary, as explained further in section V.E. of this final rule. As we have explained above, once a procedure becomes safe enough to be performed in more than 50 percent of cases in the office setting, it is unlikely to revert to a facility setting.

The vast majority of procedures designated as office-based under the revised ASC payment system would require only either local anesthesia or at most moderate or ''conscious'' sedation, that is, sedation to achieve a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes, and ability to respond to stimulation or verbal commands. The use of general anesthesia for the performance of these office-based procedures would be expected to be highly unusual. In those cases where local anesthesia or ''conscious'' sedation are the typical types of anesthesia used in the performance of certain procedures, the procedure's MPFS nonfacility practice expense amount would have already been valued to include payment for the anesthesia typically used, so appropriate payment would be provided in the ASC setting if the procedure were subject to the office-based payment limitation. However, even when general anesthesia may be required because of uncommon patient-specific considerations, basing a surgical procedure's prospective payment rate on the typical case when anesthesia is not required and the procedure can be performed safely in the office is consistent with the averaging principle that is the basis for all our prospective payment systems, including the revised ASC payment system.

Therefore, after considering all comments received, we are finalizing our proposal, without modification, to identify office-based surgical procedures for the revised ASC payment system as those surgical procedures no longer excluded from ASC payment beginning in CY 2008 or later years that are performed more than 50 percent of the time in physicians' offices, taking into account the most recent available volume and utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. We will annually assess whether there are additional procedures that we would propose to classify as office-based as part of the annual OPPS/ASC rulemaking cycle. With the exception of new codes for which our determinations would remain preliminary until there are adequate physicians' claims data available to assess their predominant sites of service as discussed further in section V.E. of this final rule, the classification of a procedure as office-based would not change in future updates of the ASC payment system. Those procedures whose office-based designation for CY 2008 is temporary because they are new codes for which there is not yet adequate physicians' claims data are flagged with an asterisk (*) in Addendum AA to this final rule.

Comment: One commenter indicated that code CPT 64555 (Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes

sacral nerve)), should not be designated as an office-based procedure under the revised ASC payment system because not all of the procedures described by the code can be done in the physician's office. The commenter further stated that payment accuracy should be included as a goal of any new payment system, to avoid site-of-service decisions that are based on financial factors rather than clinical appropriateness. The commenter reasoned that the proposed payment method for procedures similarly identified as office-based would inappropriately impact site-of-service decisions, because it would not be possible to provide the procedures in the ASC setting.

Another commenter suggested that CPT code 15340 (Tissue cultured allogeneic skin substitute, first 25 sq cm or less) be removed from the proposed list of office-based procedures so as to ensure appropriate payment for the procedure in the ASC setting and thereby provide Medicare beneficiaries with increased access to the procedure. The commenter noted that this CPT code was new for CY 2006 and, therefore, there were no CY 2005 utilization data available for our review. They also explained that the predecessor CPT code was not performed in the physician's office more than 50 percent of the time, and they did not believe this new code would be determined to be office-based based on the 50-percent threshold when CY 2006 data were available.

Response: We have identified CPT code 64555, newly proposed for ASC payment beginning in CY 2008, as a device-intensive procedure that is clinically similar to other CPT codes for implantation of neuroelectrodes that are not office-based procedures, although some of the other procedures are ASC covered surgical procedures prior to January 2008. The code is assigned to APC 0040 (Percutaneous Implantation of Neurostimulator Electrodes, Excluding Cranial Nerve) under the CY 2007 OPPS, where other neurostimatulor electrode implantation procedures reside. Therefore, we believe it is most appropriate to remove CPT code 64555 from the list of office-based procedures under the revised ASC payment system, so that it will be paid in the ASC setting according to the modified payment methodology we are adopting for device-intensive procedures. We refer readers to section IV.C.2.e. of this final rule for a detailed discussion of our proposed and final policies regarding ASC payment for procedures with significant device costs. In addition, we note that, while we had also proposed an office-based designation for CPT code 64565 (Percutaneous implantation of neurostimulator electrodes; neuromuscular) beginning with its initial ASC payment in CY 2008, under the OPPS this code is assigned to the same clinical APC as CPT code 64555, which it resembles from both clinical and facility resource perspectives. Therefore, we will also remove CPT code 64565 from the list of office-based procedures for the CY 2008 revised ASC payment system. Following the removal of these two codes from the list of office-based procedures, there are no ASC covered surgical procedures that are both device-intensive and office-based for the CY 2008 revised ASC payment system.

With respect to CPT code 15340, as the commenter pointed out, we have no utilization data from CY 2005 available for this procedure to review in developing this final rule. We note that we did not propose to designate the CPT add-on code for an additional area of application, 15341 (Tissue cultured allogeneic skin substitute, each additional 25 sq cm) as office-based under the revised ASC payment system. The proposed ASC treatment of CPT code 15340 was a temporary designation for the new code, subject to change in response to public comments and our examination of utilization data when available. At this time, we have decided to remove this CPT code from the office-based list because, after further review, we believe it is not likely to be performed more than 50 percent of the time in the physician's office setting. However, we will continue to evaluate the appropriateness of this action as new data become available and will annually reassess whether this code, or other procedures newly paid in ASCs in CY 2008 or later years that are not already designated as office-based or for which that classification is temporary, should be proposed as office-based for ASC payment, in the context of each year's OPPS/ASC annual update. We note, specifically, that our treatment of CPT code 15340 in this CY 2008 ASC final rule is not a final determination for CY 2008, because we expect to have CY 2006 utilization data available for the CY 2008 OPPS/ASC proposed rule, where we may propose that additional codes be classified as office-based for the CY 2008 revised ASC payment system.

After considering all public comments received, we are finalizing our proposal, with modification, of the office-based list of covered surgical procedures under the CY 2008 revised ASC payment system. At this point, we are removing CPT codes 64555, 64565, and 15340 from the office-based list for the CY 2008 revised ASC payment system. As new data become available, we may propose that additional HCPCS codes newly paid in ASCs in CY 2008 be classified as office-based in the CY 2008 OPPS/ASC proposed rule, and the final CY 2008 ASC list of covered office-based surgical procedures will be published in the CY 2008 OPPS/ASC final rule.

F. Payment Policies for Multiple and Interrupted Procedures

1. Multiple Procedure Discounting Policy

In the August 2006 proposed rule for the revised ASC payment system, we proposed to mirror the OPPS policy for discounting when a beneficiary has more than one surgical procedure performed on the same day at an ASC facility (71 FR 49651). The current policy for multiple procedure discounting in the ASC, as specified in § 416.120(c)(2)(ii) of our regulations, 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; therefore, 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. Although the ASC 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 methodology.

Under the revised ASC payment system in the August 2006 proposed rule, we proposed to package payment for implantable devices into the procedure payment made to the ASC, as under the OPPS. Because we are trying wherever possible to implement parallel payment policies across both systems, we proposed to adopt the OPPS discounting policy that is applied to surgical procedures so that the costs of performing multiple procedures for the implantation of costly devices are taken into account. Thus, payment for the

same set of multiple procedures under the OPPS and the ASC payment system would be made using similar packaging and payment rules.

For the revised ASC payment system, we proposed in Table 46 of the August 2006 proposed rule (71 FR 49652) a listing of the covered surgical procedures that would be exempt from multiple procedure discounting based on CY 2007 OPPS proposed procedure-specific discounting designations (71 FR 49652 through 49654). These exempt procedures were those surgical procedures proposed for ASC payment in CY 2008 that were also proposed for assignment to a status indicator other than ''T'' under the CY 2007 OPPS, indicating that a multiple surgical procedure reduction would not apply. We proposed to update this list annually in the OPPS/ASC proposed and final rules, and solicited comments on the list.

We also proposed to incorporate our proposed policy on multiple procedure discounting in proposed new § 416.172(e).

Comment: Several commenters supported our proposal to apply the multiple procedure discounting policy of the OPPS to procedures provided under the revised ASC payment system. The commenters noted that this policy would ensure that payments for ASC covered surgical procedures with high fixed costs are not discounted, and that the full costs of procedures to implant expensive devices are taken into account when these device-intensive procedures are performed in conjunction with other surgical procedures. The commenters also suggested that adopting the OPPS multiple procedure discounting policy would provide parity in payments to both HOPDs and ASCs, as well as minimize any payment incentive to shift services between the two settings because of different policies. They believed that this consistency would result in appropriate and parallel policies for payment of multiple surgical procedures performed in a single operative session in both of these delivery settings where outpatient surgery is commonly performed.

Response: We appreciate the commenters' support for the proposed ASC multiple procedure discounting policy. Specifically, when more than one covered surgical procedure is provided by an ASC in a single operative session to a Medicare beneficiary, the procedure with the highest ASC payment rate would be paid 100 percent of the ASC payment amount, and ASC payments for any other surgical procedures not expressly exempt from the discounting policy would be reduced by half. Certain ASC covered surgical procedures with relatively high fixed costs would be specifically exempt from the ASC multiple procedure discounting policy, consistent with the current OPPS multiple procedure discounting policy for those surgical procedures assigned to a status indicator other than ''T'' under the OPPS. We agree with the commenters' general reasoning and further believe that adopting an ASC policy that parallels the OPPS discounting policy would assist in timely and coordinated updates to the multiple procedure discounting status of services payable under both payment systems.

Comment: Several commenters indicated that CMS inappropriately included only one of three similar CPT codes for the placement of breast brachytherapy catheters (specifically CPT code 19298 (Placement of radiotherapy after loading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes imaging guidance)) on the list of procedures proposed for exemption from multiple procedure discounting, which was provided as Table 46 in the CY 2008 ASC proposed rule (and which has been updated as Table 10 below based on the CY 2007 OPPS final procedure-specific discounting designations). These commenters explained that the general surgical approach and devices required to perform CPT code 19298 are similar to those used to provide CPT code 19296 (Placement of radiotherapy after loading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; on date separate from partial mastectomy) and CPT code 19297 (Placement of radiotherapy after loading balloon catheter into the breast for interstitial radioelement application following partial mastectomy, includes imaging guidance; concurrent with partial mastectomy). Moreover, the commenters believed that, because all three CPT codes are assigned to status indicator ''S'' under the OPPS, indicating that multiple procedure discounting does not apply to payment for their performance in the hospital outpatient setting, all of these codes should also be exempt from multiple procedure discounting under the revised ASC payment system.

Response: While CPT code 19298 is assigned to status indicator ''S'' under the CY 2007 OPPS, CPT codes 19296 and 19297 are assigned to status indicator ''T'' under the OPPS effective January 1, 2007. As discussed in the CY 2007 OPPS final rule with comment period (71 FR 68028), CPT codes 19296 and 19297 were reassigned from New Technology APCs to a clinical APC effective January 1, 2007. Along with their APC reassignments, CPT codes 19296 and 19297 were also reassigned from status indicator ''S'' to ''T'' effective January 1, 2007. During the CY 2007 OPPS rulemaking cycle, in considering the public comments and finalizing the new assignments of CPT codes 19296 and 19297 to a clinical APC with status indicator ''T,'' the implications of the multiple procedure reduction to payment for CPT codes 19296 and 19297 in various clinical scenarios were taken into consideration. Therefore, consistent with our proposed multiple procedure discounting policy for the revised ASC payment system, these two procedures were not included on the proposed list of procedures for exemption from multiple procedure discounting under the revised ASC payment system. Their OPPS payment status of ''T'' implies that the multiple procedure payment reduction would be appropriate, and the possibility of a 50-percent payment reduction has already specifically been evaluated with respect to the hospital outpatient resources required to perform the procedures. However, because CPT code 19298 is assigned to status indicator ''S'' under the CY 2007 OPPS, where it remains in its original New Technology APC while additional hospital cost data are being collected, we believe that CPT code 19298 would be appropriately exempted from multiple procedure discounting in both the ASC and HOPD settings, consistent with our overall proposal for discounting under the revised ASC payment system.

After considering the public comments we received, we are finalizing our proposed payment policy for multiple surgical procedure discounting under the revised ASC payment system under § 416.172(e) with only editorial modification. We will mirror the OPPS payment policy for discounting when a beneficiary has more than one covered surgical procedure performed in a single operative session in an ASC in CY 2008, by exempting those surgical procedures on the ASC list of covered surgical procedures that are assigned to a status indicator other than ''T'' under the CY 2008 OPPS from multiple procedure discounting under the revised ASC payment system. The discounting policy of the revised ASC payment system, like

the policy of the existing ASC payment system, will apply the multiple procedure reduction if the same procedure is performed bilaterally, consistent with the general discounting policy of the OPPS for payment of surgical procedures that are performed bilaterally. A procedure performed bilaterally in one operative session would be paid at 150 percent of the single procedure payment under the revised ASC payment system. The multiple procedure discounting policy will only apply to ASC payment for covered surgical procedures. ASC payment for covered ancillary services, as discussed further in section IV.C.2. of this final rule, will not be subject to the multiple procedure discount.

The specific multiple procedure discounting policy that applies to each ASC covered surgical procedure is identified in Addendum AA to this final rule. Table 10 provides an illustrative summary list of the CY 2007 HCPCS codes on the ASC list of covered surgical procedures for CY 2008, and their respective APCs as of January 1, 2007 under the OPPS, which will be exempt from multiple procedure discounting in ASCs effective January 1, 2008, if no changes are made to their OPPS discounting designation for CY 2008. We will update this list annually in the OPPS/ASC proposed and final rulemaking process, which includes the solicitation of public comments. The CY 2008 list of exemptions will be proposed and finalized for the CY 2008 revised ASC payment system through the OPPS/ASC rulemaking cycle for CY 2008.

TABLE 10.—ILLUSTRATIVE LIST OF PROCEDURES EXEMPT FROM MULTIPLE PROCEDURE DISCOUNTING UNDER THE REVISED ASC PAYMENT SYSTEM IN CY 2008

HCPCS code	Short descriptor	APC
11980	Implant hormone pellet(s).	0340
11981	Insert drug implant device.	0340
11982	Remove drug implant device.	0340
11983	Remove/insert drug implant.	0340
15852	Dressing change not for burn.	0340
15860	Test for blood flow in graft.	0340
19295	Place breast clip, percut	0657
19298	Place breast rad tube/caths.	1524
20665	Removal of fixation device.	0340

TABLE 10.—ILLUSTRATIVE LIST OF PROCEDURES EXEMPT FROM MULTIPLE PROCEDURE DISCOUNTING UNDER THE REVISED ASC PAYMENT SYSTEM IN CY 2008—Continued

HCPCS code	Short descriptor	APC
20975	Electrical bone stimulation.	0340
20979	Us bone stimulation	0340
29010	Application of body cast	0426
29015	Application of body cast	0426
29020	Application of body cast	0058
29025	Application of body cast	0058
29035	Application of body cast	0426
29040	Application of body cast	0058
29044	Application of body cast	0426
29049	Application of figure eight.	0058
29055	Application of shoulder cast.	0426
29058	Application of shoulder cast.	0058
29065	Application of long arm cast.	0426
29075	Application of forearm cast.	0426
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
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
29440	Addition of walker to cast.	0058
29445	Apply rigid leg cast	0426
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
29580	Application of paste boot.	0058
29590	Application of foot splint	0058

TABLE 10.—ILLUSTRATIVE LIST OF PROCEDURES EXEMPT FROM MULTIPLE PROCEDURE DISCOUNTING UNDER THE REVISED ASC PAYMENT SYSTEM IN CY 2008—Continued

HCPCS code	Short descriptor	APC
29700	Removal/revision of cast.	0058
29705	Removal/revision of cast.	0058
29710	Removal/revision of cast.	0426
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
30300	Remove nasal foreign body.	0340
31500	Insert emergency airway.	0094
31620	Endobronchial us add-on.	0670
33282	Implant pat-active ht record.	0680
36002	Pseudoaneurysm injection trt.	0267
36430	Blood transfusion service.	0110
36440	Bl push transfuse, 2 yr or <.	0110
36450	Bl exchange/transfuse, nb.	0110
36511	Apheresis wbc	0111
36512	Apheresis rbc	0111
36513	Apheresis platelets	0111
36514	Apheresis plasma	0111
36515	Apheresis, adsorp/reinfuse.	0112
36516	Apheresis, selective	0112
36522	Photopheresis	0112
36598	Inj w/fluor, eval cv device.	0340
37250	Iv us first vessel add-on	0416
37251	Iv us each add vessel add-on.	0416
38205	Harvest allogenic stem cells.	0111
38206	Harvest auto stem cells	0111
38230	Bone marrow collection	0123
38241	Bone marrow/stem transplant.	0123
38242	Lymphocyte infuse transplant.	0111
40804	Removal, foreign body, mouth.	0340
42809	Remove pharynx foreign body.	0340
46600	Diagnostic anoscopy	0340
51701	Insert bladder catheter	0340
51702	Insert temp bladder cath.	0340
51798	Us urine capacity measure.	0340
53440	Male sling procedure	0385
53444	Insert tandem cuff	0385
53445	Insert uro/ves nck sphincter.	0386
53447	Remove/replace ur sphincter.	0386

TABLE 10.—ILLUSTRATIVE LIST OF PROCEDURES EXEMPT FROM MULTIPLE PROCEDURE DISCOUNTING UNDER THE REVISED ASC PAYMENT SYSTEM IN CY 2008—Continued

HCPCS code	Short descriptor	APC
54400	Insert semi-rigid prosthesis.	0385
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
61795	Brain surgery using computer.	0302
61885	Insrt/redo neurostim 1 array.	0039
62252	Csf shunt reprogram	0691
62367	Analyze spine infusion pump.	0691
62368	Analyze spine infusion pump.	0691
63650	Implant neuroelectrodes	0040
63655	Implant neuroelectrodes	0061
64553	Implant neuroelectrodes	0225
64555	Implant neuroelectrodes	0040
64560	Implant neuroelectrodes	0040
64561	Implant neuroelectrodes	0040
64565	Implant neuroelectrodes	0040
64573	Implant neuroelectrodes	0225
64575	Implant neuroelectrodes	0061
64577	Implant neuroelectrodes	0061
64580	Implant neuroelectrodes	0061
64581	Implant neuroelectrodes	0061
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
65450	Treatment of corneal lesion.	0231
67500	Inject/treat eye socket	0231
67820	Revise eyelashes	0698
67938	Remove eyelid foreign body.	0698
68040	Treatment of eyelid lesions.	0698
68200	Treat eyelid by injection	0230
68760	Close tear duct opening	0231
68761	Close tear duct opening	0231
68801	Dilate tear duct opening	0698
68810	Probe nasolacrimal duct	0231
68840	Explore/irrigate tear ducts.	0698
69200	Clear outer ear canal	0340
69210	Remove impacted ear wax.	0340
C9725	Place endorectal app	1507
C9726	Rxt breast appl place/remov.	1508
C9727	Insert palate implants	1510
G0104	CA screen; flexi sigmoidscope.	0159

2. Interrupted Procedure Policies

When a procedure requiring anesthesia is discontinued after the beneficiary is prepared for the procedure and taken to the room where it is to be performed, but before the administration of anesthesia, ASCs currently report modifier 73 (Discontinued outpatient procedure prior to anesthesia administration) appended to the discontinued procedure and receive 50 percent of the ASC payment for the planned surgical procedure. We believe that ASCs, like hospital outpatient facilities, realize significant savings when procedures for which anesthesia is to be used are discontinued prior to their initiation but after the beneficiary is taken to the procedure room. We believe that savings are recognized for the costs associated with a variety of facility resources, including treatment/operating room time, single use devices, drugs, equipment, supplies, and recovery room time. When a procedure is interrupted after its initiation or the administration of anesthesia, ASCs currently report these cases using modifier 74 (Discontinued outpatient procedure after anesthesia administration) appended to the interrupted procedure, and the full ASC payment for the covered surgical procedure is made. Similar to hospital outpatient procedures that are discontinued after the administration of anesthesia or the initiation of the procedure, in cases where modifier 74 is reported by ASCs, we believe that the facility costs incurred for these discontinued procedures that were initiated to some degree are generally as significant to the ASC as those for a completed procedure, including resources for patient preparation, operating room use, and recovery room care. In the August 2006 proposed rule, we proposed no change to the existing ASC payment policy for procedures reported with modifier 73 or 74 under the revised ASC payment system, and note that the policy under the existing ASC payment system is the same as the OPPS policy in these circumstances.

Under the existing ASC payment system, ASCs do not report modifier 52 (Reduced services) for interrupted procedures, because most interrupted covered surgical procedures paid in ASCs would be appropriately reported with modifier 73 or 74 because they generally require anesthesia. Modifier 52 is appended to a service under the OPPS to signify that a service that did not require anesthesia was partially reduced or discontinued at the physician's discretion. Modifier 52 is reported under the OPPS for a variety of types of interrupted services, such as radiology services, and we believe that there are considerable resource savings to the facility under the circumstances where it is reported. Therefore, under the OPPS, we apply a 50 percent reduction to the facility payment for interrupted procedures and services reported with modifier 52.

The PPAC recommended that we apply payment policies consistently under the revised ASC payment system and the OPPS. We received a number of public comments recommending consistency of payment policies between the two payment systems. Although not discussed in our proposed rule for the revised ASC payment system, we received comments on the application of the current interrupted procedure policies to the revised ASC payment system and respond to these comments below.

Comment: Many commenters recommended that we establish consistent payment policies under the OPPS and the revised ASC payment system, because the hospital and ASC facilities provide many of the same services to similar patients. In particular, several commenters compared current payment policies that were similar between the existing ASC payment system and the OPPS, including the payment policy that reduces the payment for interrupted procedures reported with modifier 73 by 50 percent in both payment systems.

Response: We agree with commenters that consistent policies between the revised ASC payment system and the OPPS are desirable whenever possible, because the revised ASC payment system will be based upon the OPPS relative payment weights. We also note that, with the significant expansion of procedures eligible for ASC payment under the revised ASC payment system, it is possible that some of the additional procedures payable in the ASC setting beginning in CY 2008 may not always require anesthesia. In addition, as further discussed in section IV.C.2. of this final rule, we will be providing separate payment for some ancillary radiology services that are integral to the performance of covered surgical procedures under the revised ASC payment system. Therefore, we believe that the revised ASC payment system should also allow ASCs to report interrupted services not requiring anesthesia with modifier 52, consistent with the OPPS reporting of these services. Because we expect ASCs to utilize fewer facility resources in such situations, similar to ASC procedures where modifier 73 is reported and to

HOPDs where modifier 73 or 52 is reported, we believe that it is appropriate to provide the same payment reduction of 50 percent under the revised ASC payment system as under the OPPS when modifier 52 is reported.

After considering the public comments received, we are clarifying here the payment policies for interrupted procedures in ASCs. First, procedures requiring anesthesia that are terminated after the patient has been prepared for surgery and taken to the operating room but before the administration of anesthesia will be reported with modifier 73, and the ASC payment for the covered surgical procedure will be reduced by 50 percent. Second, procedures and services not requiring anesthesia that are partially reduced or discontinued at the physician's discretion will be reported with modifier 52, and the ASC payment for the covered surgical procedure or covered ancillary service will be reduced by 50 percent. Third, procedures requiring anesthesia that are terminated after the administration of anesthesia or the initiation of the procedure will be reported with modifier 74, and the full ASC payment for the covered surgical procedure will be provided. We are adding new § 416.172(f) to reflect this final policy.

G. Geographic Adjustment

Currently, Medicare adjusts 34.45 percent of the national ASC payment rates using wage index values and localities that were established under the hospital IPPS prior to implementation of the new 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 Public Law 108–173.

Since 1990, ASC payments have been adjusted for regional wage variations using the IPPS wage index values. As we discussed in the August 2006 proposed rule, we believe that standardization continues to be appropriate in recognition of widely varying labor market costs tied to geographic localities. We also explained in the proposed rule that we believe it is advisable to maintain 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 proposed 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 had not collected new data to identify whether the current labor-related share is correct, the results of a 1994 survey of ASC costs generally supported the current 34.45-percent labor adjustment factor, and we had received no complaints from the ASC community, prior to our proposal, 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, in the proposed rule, we stated our belief that it is reasonable to expect ASCs to have a lower labor adjustment factor than that of hospitals. For example, most OPPS HOPDs are staffed 24 hours per day to provide emergency department services and observation care, and these patterns of operation could lead to relatively higher labor costs for hospital services overall. Therefore, we proposed to continue using 34.45 percent as the labor adjustment factor for regional wage differences under the revised ASC payment system, beginning in CY 2008. We proposed to establish rules governing this proposal in new § 416.172(c).

Subsequent to the publication of the August 2006 proposed rule for the revised ASC payment system, the GAO issued the report, ''Medicare: Payment for Ambulatory Surgical Centers Should Be Based on the Hospital Outpatient Payment System,'' (GAO–07–86), which is discussed in further detail in section II.B. of this final rule. In this report, the GAO determined that based upon the 2004 ASC cost data from a geographically representative group of ASCs received in response to its ASC survey, the mean labor-related proportion of ASC costs was 50 percent.

Comment: Several commenters agreed with CMS' proposal to use the IPPS pre-reclassification wage index values associated with the June 2003 OMB geographic localities. However, many commenters indicated that the current 34.45-percent labor factor is based on old data and is too low, leading to their recommendation that the 60-percent OPPS labor factor would be more appropriate. Some commenters explained that it was difficult to assess the appropriateness of CMS' proposal in the absence of the GAO Report on the ASC payment system that was directed to address whether a geographic adjustment should be provided for payment of procedures furnished in ASCs and, if so, the labor and nonlabor shares of ASC payment. Other commenters recommended that CMS collect more recent data on the costs of delivering services in the ASC setting or suggested that ASCs be asked to submit cost reports to inform the development of an appropriate, contemporary labor factor reflecting current ASC costs.

Response: For the reasons stated in the proposed rule and reiterated above, we agree with the commenters that we should use the IPPS pre-reclassification wage index values associated with the June 2003 OMB geographic localities. While we share the concerns of commenters about the age of the survey data used for the current 34.45-percent labor factor, we disagree that it would be appropriate to use the same 60-percent labor factor used under the OPPS. The commenters who indicated a preference for the OPPS labor factor did not address the fact that most OPPS HOPDs are staffed 24 hours per day to provide emergency department services and observation care. Other than their request for parity with the OPPS labor adjustment, they provided no specific data to support the appropriateness of a 60-percent labor factor based on current ASC costs for performing procedures.

However, we agree with commenters that the 34.45 labor-related share that we proposed for the revised payment system is likely too low to accurately reflect the current proportion of ASCs' labor costs. The data used to develop the 34.45 labor-related share are 20 years old, and 1994 ASC survey cost data, which have never been used for ASC payment, showed a slightly higher labor-related share of 37.66 percent that we believe was likely reflective of a generally increasing proportion of ASC labor costs. ASCs and HOPDs operate in some of the same communities, using similar clinical staff to perform certain procedures, and ASC staff wages may be comparable to those of hospital staff. However, we have no data to indicate that ASCs and HOPDs have equivalent ratios of labor to nonlabor costs, on average, for all the services each type of facility provides. As discussed above, because ASCs only provide a subset of surgical procedures compared with the wide variety of OPPS services that we expect could be, overall, relatively more labor-intensive than ambulatory surgical procedures specifically, we believe that the most appropriate ASC labor-related share would be lower than the 60 percent used to adjust HOPD payment. The GAO Report determined, on the basis of the 2004 ASC cost data received from a geographically representative group of ASCs in response to its ASC survey, that the mean labor-related

proportion of costs was 50 percent. In addition, the GAO found that the range of the labor-related costs for the middle 50 percent of ASCs responding to the survey was relatively narrow, at 43 percent to 57 percent of total costs.

Therefore, in response to comments about the age of the historical data used for the existing and proposed revised ASC payment system labor factor, in addition to consideration of the GAO's determination based on the most recent ASC survey findings, we reviewed the labor-related share indicated by the 1994 ASC survey cost data and assessed the clinical labor required to provide both ASC and OPPS services, in the context of the full facility resource costs associated with those services. Based on all of those considerations, we believe that it is not necessary to collect additional ASC cost data in order to determine the appropriate labor-related factor for use under the revised ASC payment system and that a 50-percent labor factor for the revised ASC payment system is most appropriate. Fifty percent is significantly higher than the current labor-related share (34.45 percent) that we proposed to maintain but is also lower than the OPPS labor-related share of 60 percent, a differential we believe is appropriate given the broader range of labor-intensive services provided in the HOPD setting. A 50-percent labor-related share is fully consistent with the GAO findings that we believe provide a more accurate representation of the present-day labor-related proportion of ASC costs than the data upon which we currently rely. In the future, if we believe that the collection of additional ASC cost data is important to providing appropriate payment to ASCs and such an activity is administratively feasible, we may consider gathering such information from ASCs.

After considering the public comments received, we are finalizing our proposal to apply to ASC payments under the revised ASC payment system the IPPS pre-reclassification wage index values associated with the June 2003 OMB geographic localities, as recognized under the IPPS and OPPS, in order to adjust national ASC payment rates for geographic wage differences under the revised payment system. However, rather than adopting 34.45 percent as the labor adjustment factor as we proposed, we are adopting 50 percent as the labor-related proportion under the revised ASC payment system. The geographic adjustment policy of the revised ASC payment system is set forth in § 416.172(c).

H. Adjustment for Inflation

As noted above, section 1833(i)(2)(C)(iv) of the Act, as amended by section 626(a) of Public Law 108–173, requires the adjustment of ASC payment 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 payment amounts are to be adjusted by the percentage increase in the CPI–U during years when the ASC payment amounts are not updated.

Although we are only required to increase the ASC payment rates by the percentage increase in the CPI–U during years in which we have not updated the ASC payment amounts, we proposed to update the ASC conversion factor annually using the CPI–U. For CY 2008 and CY 2009, the statute requires a zero percent CPI–U increase for ASC services. Beginning in CY 2010, in the August 2006 proposed rule for the revised ASC payment system, we proposed to 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. Accordingly, we proposed to establish rules in proposed new §§ 416.171 and 416.172 to reflect our proposed policy for applying an inflation adjustment under the proposed revised payment system beginning January 1, 2008. (These sections of the proposed regulations also included our proposed policies for calculating a conversion factor and standardizing labor-related costs, respectively, under the proposed revised payment system.)

Comment: A number of commenters recommended that CMS use the hospital market basket as an update for inflation in the revised ASC payment system. The commenters generally indicated that the hospital market basket more appropriately reflects inflation in the costs of providing surgical services. These commenters pointed out that the CPI–U is a measure of consumer inflation rather than health care provider inflation, and that the hospital market basket was specifically designed to measure the cost of hospital inflation. They concluded that the hospital market basket is, thus, a better proxy for the inflationary pressures faced by ASCs. One commenter presented data indicating that the cost of operating an ASC rose by an average of 13.4 percent between 2003 and 2005 and that, during that same period, the CPI–U fell 36 percent short of meeting these increased costs.

Some commenters expressed concern that the use of two different factors to update payments for ASCs and HOPDs would further increase the discrepancies between payments in the two settings. They further suggested that alignment with hospital updates and policies in general would achieve parity and transparency in the market and ensure that facility decisions are made based upon what is best for the patient. Other commenters suggested that CMS develop another method that would more closely approximate the rising cost of operating an ASC if the proposal to base the annual update of the ASC conversion factor on the CPI–U is finalized.

Response: As we explained in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68003), the OPPS conversion factor is updated annually using the hospital inpatient market basket percentage increase. The statute specifically required us to take into account the recommendations of a GAO Report studying the appropriateness of aligning a revised ASC payment system with the payment rates and relative weights established under the OPPS. However, the statute gives the Secretary broad authority in designing the specific features of the revised system. In particular, the statute gives the Secretary considerable discretion in determining an appropriate update mechanism for the revised ASC payment system. Section 1833(i)(2)(C)(i) of the Act requires that the Secretary update the payment amounts established under the revised system ''by the percentage increase in the Consumer Price Index for all urban consumers,'' but only if the Secretary has not otherwise ''updated amounts established'' under the revised system for that year. The statute, therefore, does not mandate the adoption of any particular update mechanism, but it does establish the CPI–U as the default update mechanism in the absence of any other update. In addition, section 1833(i)(2)(C)(iv) of the Act mandates a zero CPI–U adjustment in CY 2008 and CY 2009 for ASCs, the first 2 years under the revised payment system, suggesting that maintaining continuity in the update mechanism under the revised system may be appropriate. Therefore, we proposed, under the revised system beginning in CY 2010, to apply the CPI–U adjustment to update the ASC conversion factor for inflation on an annual basis. While we understand the arguments of commenters in favor of adopting the hospital market basket as the update mechanism under the revised ASC

payment system, we continue to believe that it is appropriate to adopt the default update mechanism designated by Congress for the revised system.

Therefore, we are finalizing our proposal, beginning in CY 2010, to update the 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. At the same time, we recognize that we continue to have flexibility under the statute to employ a different update mechanism under the revised ASC payment system. As one example, we do not intend for the revised ASC payment system to result in additional Medicare expenditures over time. We will be monitoring this issue closely in the coming years. Consequently, we will reconsider the ASC update if expenditures increase inappropriately in future years.

Therefore, after consideration of all public comments received, we are finalizing our proposal under § 416.171(a)(2), without modification, to apply the CPI–U to update the ASC conversion factor for inflation on an annual basis under the revised ASC payment system.

I. Beneficiary Coinsurance

Payment for ASC services is subject to the Medicare Part B deductible and coinsurance requirements. Currently, Medicare pays participating ASCs 80 percent of a prospectively determined standard overhead amount, adjusted for regional wage variations for ASC covered surgical procedures, except for screening colonoscopies. The beneficiary deductible and coinsurance make up the other 20 percent of payment for ASC services, except for screening colonoscopies for which there is no deductible and for which the coinsurance is equal to 25 percent. Section 1834(d) of the Act requires this higher coinsurance for screening colonoscopies and screening flexible sigmoidoscopies. However, only screening colonoscopies are on the CY 2007 ASC list of covered surgical procedures. In addition, effective January 1, 2007, a deductible is no longer applied for colorectal cancer screening tests, including screening flexible sigmoidoscopy and screening colonoscopy procedures performed in ASCs or other settings, as specified in section 1833(b)(8) of the Act (as added by section 5113 of Public Law 109–171).

Section 626(c) of Public Law 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. This amendment, however, did not affect section 1834(d) of the Act. Therefore, we proposed to make this change and to continue to maintain the beneficiary deductible and coinsurance at 20 percent under the revised ASC payment system, except for screening colonoscopies and screening flexible sigmoidoscopies (which are both ASC covered surgical procedures in CY 2008) for which the statute requires 25 percent beneficiary coinsurance. In the August 2006 proposed rule for the revised ASC payment system, we proposed to reflect the 20 percent beneficiary coinsurance in proposed new §§ 416.172(b) and (d); however, the proposed regulation text did not address the statutory requirement of 25 percent coinsurance for screening flexible sigmoidoscopies and screening colonoscopies. Consistent with the provisions of section 1834(d) of the Act, we implemented the 25 percent coinsurance requirement for screening colonoscopies (screening flexible sigmoidoscopies are not on the CY 2007 ASC list of covered surgical procedures) in ASCs, effective January 1, 2007, as finalized in § 410.152(i) and discussed in the preamble to the CY 2007 OPPS/ASC final rule with comment period (71 FR 68174).

Comment: Many commenters supported our proposal to continue to apply the 20 percent coinsurance provision to payment for covered surgical procedures performed in ASCs and paid under the revised ASC payment system.

Response: We appreciate the comments. The statute requires Medicare to pay 80 percent of the lesser of the actual charge for the service or the amount we determine under the revised payment system, other than for screening colonoscopy and screening flexible sigmoidoscopy procedures. Beneficiary coinsurance will remain at 20 percent for ASC services under the revised ASC payment system, except for screening flexible sigmoidoscopy and screening colonoscopy procedures. The coinsurance for screening colonoscopies and screening flexible sigmoidoscopies will be 25 percent, as required by section 1834(d) of the Act, with no deductible for those services under the revised ASC payment system. This requirement is reflected in our regulations at §§ 416.172(b) and (d).

J. Phase-In of Full Implementation of Payment Rates Calculated Under the Revised ASC Payment System Methodology

We discussed in section XXVII.D. of the preamble to the August 2006 proposed rule for the revised ASC payment system (71 FR 49690 through 49695), our analysis of the impact that the revised ASC payment system and estimated payment rates 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 wanted 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 under Medicare.

In the August 2006 proposed rule, we proposed 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 CY 2007 ASC payment rate for a procedure on the CY 2007 ASC list of covered surgical procedures and the final payment rate for that same procedure calculated under the revised payment system methodology described in the proposed rule and reflected in proposed new § 416.171(c). We further proposed that, in CY 2009, we would fully implement the ASC payment rates calculated under the proposed payment methodology, discontinuing the blended transitional payment rates for services furnished beginning January 1, 2009. This was proposed in new § 416.171(d).

Comment: Several commenters expressed concern that the proposed 2-year transition period would threaten the viability of many ASCs. The commenters indicated that given the size of the payment cuts contemplated under the proposed rule for certain procedures and specialties, especially gastrointestinal, pain management, and ophthalmology services, 1 year would not provide adequate time for ASCs to adjust to the changes and that a 4-year phase-in would allow a more gradual and less disruptive transition to the new payment system. Many commenters urged CMS to implement policies to further address the decrease in payments for procedures whose rates would fall significantly during a

transition to the new payment system. One commenter suggested that CMS hold harmless procedures that were on the ASC list of covered surgical procedures prior to CY 2008 to prevent significant changes in payments during the transition. Some commenters expressed concern that if CMS revises both the payment system and the geographic localities used for wage adjustment at the same time, providers in certain areas could experience dramatic shifts in payment as a result of the cumulative effect of the wage index and other policy changes that were described in the proposed rule. These commenters encouraged CMS to consider the cumulative effects of the wage index and other policy changes on payments to ASCs under the revised ASC payment system and develop a transitional approach that protects providers from significant reductions in payment.

A number of commenters supported the proposed 2-year phase-in of the ASC payment rates based on the final methodology of the revised ASC payment system. The commenters generally believed that the transition period as proposed would provide sufficient notice and time for ASCs to adapt to the revised payment system.

Some commenters stated that the proposed transition does not appropriately address payment for device-intensive procedures that implant devices that are paid separately according to the DMEPOS fee schedule under the existing payment system during the transitional year of CY 2008. Some of these commenters urged CMS to devise a strategy that would accelerate full implementation of payment for device-intensive procedures according to the proposed methodology for the revised ASC payment system. Alternatively, other commenters suggested that CMS develop a final transitional policy that does not exclude the payments for implanted devices now paid separately under the DMEPOS fee schedule in calculating the CY 2007 ASC payment contributions to the blended payment rates for device-intensive procedures for CY 2008.

Response: After consideration of all of these public comments, we agree with the majority of the commenters who indicated that a 2-year transition may provide some ASCs with insufficient time to adapt to the revised payment system. During the transition to the revised system, we believe it is important to maintain appropriate Medicare beneficiary access to ASC services. In addition, we do not believe that the transition should be asymmetrical, meaning that procedures with decreasing payments under the revised payment system should be transitioned differently from those with increasing payments. We also do not believe that the transition should lead to increases or decreases in overall Medicare ASC expenditures.

Therefore, in order to provide additional time for ASCs to adapt to the revised payment system and to facilitate Medicare beneficiary access to ambulatory surgical procedures at those ASCs that may not adjust as quickly as others to the revised payment system, we are extending the transition from our proposed 2 years to 4 years for all services on the CY 2007 ASC list of covered surgical procedures, as reflected in § 416.171(c). We believe a transition period of 4 years, comparable to transition periods provided under other payment systems (for example, the recent practice expense changes to the MPFS) and as suggested in comments concerning this issue, will provide a reasonable and balanced approach to implementation that addresses two important objectives, in particular offering sufficient notice and time for ASCs to adapt to the revised payment system and providing more accurate and appropriate ASC payments for covered surgical procedures. The contribution of CY 2007 ASC payment rates to the blended transitional rates will decrease by 25 percentage point increments each year of transitional payment, until CY 2011, when we will fully implement the ASC payment rates calculated under the final methodology of the revised payment system. Procedures new to ASC payment for CY 2008 or later calendar years will receive payments determined according to the final methodology of the revised ASC payment system, as reflected in § 416.171(a), without the need for a transition. ASC covered surgical procedures listed in Addendum AA to this final rule that are subject to the transition are assigned to payment indicators ''A2'' (Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight) and ''H8'' (Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate). ASC covered surgical procedures listed in Addendum AA to this final rule that are not subject to the transition are assigned to payment indicators ''G2'' (Non office-based surgical procedure added to ASC list in CY 2008 or later; payment based on OPPS relative payment weight); ''J8'' (Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate); ''P2'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight); ''P3'' (Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs); and ''R2'' (Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight).

In addition, we agree with commenters who indicated that an adjustment should be made during the transition period for certain procedures that implant devices that are separately payable under the existing ASC payment system. For device-intensive procedures utilizing separately payable devices of significant cost, ideally, we would adjust the CY 2007 base rates for the procedures to appropriately reflect the fact that associated devices may have been separately paid to ASCs in CY 2007 under the DMEPOS fee schedule, but beginning in CY 2008 implantable device payment will be packaged into the ASC payment for the covered surgical procedure under the revised ASC payment system. This would require associating the current separately provided implantable device payments with specific covered surgical procedures, in order to determine an appropriate CY 2007 base payment rate for the transition for each procedure. However, due to the challenges in making these associations, including the common historical practice of payment at contractor-priced rates for some implantable devices that have been reported only under Level II HCPCS unlisted codes under the existing payment system, we cannot accurately allocate those device payments to covered surgical procedures using the ASC data.

Under the final methodology of the revised ASC payment system for calculating payment for procedures with significant device costs as discussed in section IV.C.2.e. of this final rule, for device-intensive procedures on the CY 2007 ASC list of covered surgical procedures, we will separately determine both the device payment and service payment portions of the total ASC payment under the revised payment system. We will apply the ASC conversion factor only to the specially calculated OPPS relative payment weight for the service portion, while providing the same packaged payment for the device portion as would be made under the OPPS. That is, we will determine the payment amount attributable to the device, as currently determined under the OPPS, and

combine that payment amount with the adjusted ASC service payment, resulting in a total ''bundled'' ASC payment for the device-intensive procedure under the revised ASC payment system.

Consistent with that approach, we also will apply our transition policy differentially to those portions of the total ASC payment. While we will not subject the device payment portion of the total ASC payment for the procedure under the revised ASC payment system to the transition policy, we will transition the service payment portion of the total ASC payment for the procedure over the 4-year phase-in period. Device-intensive procedures that are new to the ASC list of covered surgical procedures for CY 2008 or later years will be exempted from any transition period and will be paid at the fully implemented revised ASC payment system rates beginning in CY 2008 or the applicable update year, just like all other new ASC surgical procedures. During each of the transition years, when the CY 2007 ASC payment rate for a device-intensive procedure that did not previously include packaged ASC payment for the implantable device itself is blended with the payment developed under the methodology of the revised ASC payment system that would otherwise package the device payment, the full device payment amount will be paid to ASCs in the transition year, with blended payment determined only for the service portion of the ASC payment, for which a corresponding CY 2007 ASC payment rate exists. This methodology achieves an appropriate payment for costly, implantable devices, because it recognizes that, in general, the device costs are similar for ASCs and HOPDs. This specific transition approach for device-intensive procedures ensures that ASCs receive appropriate packaged payment for implantable devices during the transition years, even though payment for such devices is generally not included in their base CY 2007 ASC payment rates under the existing ASC payment system.

A full discussion of the calculation of the payment rates for these device-intensive procedures can be found in section IV.C.2.e. of this final rule, in the context of establishing payment weights for device-intensive procedures under the revised ASC payment system. Tables 5 and 6 above are illustrative of the device-intensive procedures likely to be subject to this special transitional policy for device-intensive procedures under the revised ASC payment system, pending updating of their OPPS status in CY 2008 and future years.

After considering the public comments received, we are finalizing a policy to phase in implementation of the payment rates calculated under the revised ASC payment system over 4 years. For CYs 2008, 2009, and 2010, payment will be made for each procedure on the CY 2007 ASC list of covered surgical procedures based on a 25/75, 50/50, and 75/25 blend, respectively, of the CY 2007 payment rate for the procedure and the payment rate for that procedure calculated under the standard revised payment system methodology set forth in § 416.171(a). Procedures that are newly approved for ASC payment in CY 2008 or later years are not subject to the transition policy. In CY 2011, we will fully implement the ASC payment rates calculated under the standard payment methodology of the revised ASC payment system. This final transition policy is set forth in § 416.171(c).

The service payment portion of the total ASC payment for device-intensive procedures that are on the ASC list of covered surgical procedures in CY 2007 will be subject to the transition. The service payment portion calculated under the fully implemented revised ASC payment system methodology will be blended with the ASC payment for the procedure under the existing payment system. In contrast, the device payment portion of the total ASC payment for these procedures, where the device would generally have been paid separately according to the DMEPOS fee schedule under the existing ASC payment system, will not be subject to the transition. Rather, the contribution of the device payment portion to the total ASC payment during the transitional years will be calculated according to the methodology of the fully implemented revised ASC payment system. During the years of phase-in of the revised ASC payment system, the device payment portion will be summed with the blended service payment portion (that is, the 25/75, 50/50, or 75/25 blend, as appropriate) to establish the total ASC payment for these device-intensive procedures for each year of the transition. Device-intensive procedures new to the ASC list of covered surgical procedures for CY 2008 or later years will be paid the fully implemented revised payment system rates.

V. Calculation of ASC Conversion Factor and ASC Payment Rates for CY 2008

A. Overview

As discussed in section IV.B. of this final rule, in the August 2006 proposed rule, we proposed to base ASC relative payment weights and payment rates under the revised ASC payment system on APC groups and relative payment weights established under the OPPS. We also proposed 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 unadjusted nonfacility practice expense amount. We explained that the proposed ASC payment weights would be multiplied by an ASC conversion factor to calculate the ASC payment rates. In the August 2006 proposed rule, our estimate for the CY 2008 budget neutral ASC conversion factor was $39.688. In this final rule, we estimate that the ASC conversion factor for CY 2008 will be approximately $42.543. This new estimate of the ASC conversion factor differs from the estimate in the August 2006 proposed rule for a number of reasons, including: (1) Use of the final OPPS relative payment weights for CY 2007; (2) use of the final MPFS nonfacility practice expense payment amounts for CY 2007; (3) use of updated utilization data for the full year of CY 2005; (4) a 4-year instead of 2-year transition to the revised payment system rates, with a modified transition for device-intensive procedures; (5) more recent estimates of the hospital market basket update and the MPFS conversion factor update for CY 2008; and (6) adoption of the with-migration approach to calculation of the budget neutrality adjustment using different time periods for the assumed migration of procedures from physicians' offices and HOPDs to ASCs under the revised ASC payment system. Specific details regarding our final methodology for estimating the revised ASC payment system conversion factor are discussed later in this section.

We are not able to provide the final CY 2008 ASC conversion factor in this final rule for the revised ASC payment system because the final conversion factor will be based on the final OPPS relative payment weights for CY 2008, the final MPFS nonfacility practice expense payment amounts for CY 2008, and updated and complete CY 2006 utilization data, all of which are unavailable at this time but will be available for the CY 2008 OPPS/ASC final rule. Therefore, in this final rule, we are finalizing the methodology for calculating the ASC conversion factor for the revised ASC payment system. When the necessary data are available, they will be used in the methodology described in this final rule, and we will provide the final CY 2008 ASC conversion factor and ASC relative

payment weights and rates in the CY 2008 OPPS/ASC final rule.

B. Budget Neutrality Requirement

Section 626(b) of Public Law 108–173 amended section 1833(i)(2) of the Act by adding subparagraph (D) to require that in the year the revised ASC system is implemented:

''* * * [S]uch system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary. * * *''

As discussed in the August 2006 proposed rule for the revised ASC payment system, the ASC conversion factor is calculated so that estimated total Medicare payments under the revised ASC payment system would be budget neutral to estimated total Medicare payments under the current ASC payment system as required by the statute. That is, application of the ASC conversion factor would be designed to result in aggregate expenditures under the revised ASC payment system in CY 2008 equal to aggregate expenditures that would have occurred in CY 2008 in the absence of the revised system, taking into consideration the cap on payments in CY 2007 as required under section 5103 of Public Law 109–171, which we discuss further in section IV.A. of this final rule.

We note that, in the August 2006 proposed rule (71 FR 49656), we considered the term ''expenditures'' in the context of section 626(b) of the Public Law 108–173 budget neutrality requirement to mean expenditures from the Medicare Part B Trust Fund. We did not consider expenditures to include beneficiary coinsurance and copayments.

C. Calculation of the ASC Payment Rates for CY 2008

1. Proposed Method for Calculation of the ASC Payment Rates for CY 2008 in the August 2006 Proposed Rule

In the August 2006 proposed rule, we proposed to calculate the ASC payment rates for CY 2008 as follows:

a. Estimated Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Current ASC Payment System in the August 2006 Proposed Rule

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 HCPCS code on the CY 2007 ASC list of covered surgical procedures by the estimated CY 2008 ASC payment rate for the HCPCS code under the existing ASC system, and then subtracted beneficiary coinsurance. In the August 2006 proposed rule, the estimated CY 2008 ASC payment rates were based on the proposed CY 2007 ASC payment rates, which were listed in Addendum AA to the rule, taking into account the OPPS cap on ASC services at the OPPS rate as required by section 5103 of Public Law 109–171 and reflecting the zero percent CY 2008 update for ASC services mandated by section 1833(i)(2)(C)(iv) of the Act. Although we did not specify in the August 2006 proposed rule that we did so, we also estimated the amount the Medicare program would pay in CY 2008 for implantable prosthetic devices and implantable DME for which ASCs currently receive separate payment under the DMEPOS fee schedule. We then summed the estimated DMEPOS fee schedule total amount and all of the estimated procedure payment amounts for services on the CY 2007 ASC list of covered surgical procedures to estimate the aggregate amount of expenditures that would be made in CY 2008 under the policies of the current ASC payment system.

b. Estimated Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Proposed Revised ASC Payment System in the August 2006 Proposed Rule

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 HCPCS code on the CY 2007 ASC list of covered surgical procedures by the estimated CY 2008 OPPS payment rate for the HCPCS code, and then subtracted beneficiary coinsurance. We summed the results for all services on that ASC list of covered surgical procedures.

c. Calculation of the Proposed CY 2008 Budget Neutrality Adjustment in the August 2006 Proposed Rule

Step 3: To calculate the proposed CY 2008 ASC budget neutrality adjustment, we divided the total expenditures calculated in Step 1 by the total expenditures calculated in Step 2. We calibrated this estimate of the budget neutrality adjustment to take into account that, in CY 2008, the payment rate for procedures on the CY 2007 ASC list of covered surgical procedures was proposed to be 50 percent of the CY 2007 ASC payment amount and 50 percent of the CY 2008 ASC payment rate calculated according to the proposed revised payment system methodology without the transition. The result of these calculations was a budget neutrality adjustment of 0.62.

d. Application of the Budget Neutrality Adjustment To Determine the Proposed CY 2008 ASC Conversion Factor in the August 2006 Proposed Rule

Step 4: To determine the proposed CY 2008 ASC conversion factor, we multiplied the estimated CY 2008 OPPS conversion factor by the result of Step 3. The proposed estimated CY 2008 OPPS conversion factor was $64.013. Multiplying the estimated CY 2008 OPPS conversion factor by the 0.62 budget neutrality adjustment yielded our proposed CY 2008 ASC conversion factor of $39.688.

e. Calculation of the Proposed CY 2008 ASC Payment Rates Under the Revised ASC Payment System in the August 2006 Proposed Rule

Step 5: To determine the proposed national ASC payment rates for covered surgical procedures under the revised payment system (including beneficiary coinsurance), we multiplied the ASC conversion factor from Step 4 by the ASC relative payment weight.

The proposed ASC relative payment weights for covered surgical procedures were based on the relative payment weights for the APC groups established under the OPPS as described in section IV.B. of this final rule. However, as further discussed in section IV.E. of this final rule, the ASC relative payment weights for certain office-based surgical procedures were set so that the national ASC payment rate did not exceed the MPFS unadjusted nonfacility practice expense amount.

f. Calculation of the Proposed CY 2008 ASC Payment Rates Under the Transition in the August 2006 Proposed Rule

Step 6: We proposed to fully implement the revised ASC payment rates through a 2-year transition to 100 percent implementation of the revised ASC payment rates for procedures included on the CY 2007 ASC list of covered surgical procedures. In the first year of the transition, the payment rate would be based on 50 percent of the final CY 2007 ASC payment rate under the existing ASC payment system and 50 percent of the final CY 2008 ASC payment rate calculated under the proposed revised payment methodology. The CY 2008 payment for procedures not on the CY 2007 ASC list of covered surgical procedures, but for which we proposed to make payment

under the revised payment system beginning in CY 2008, would be made at the fully implemented revised ASC payment rates.

2. Alternative Option for Calculating the Proposed Budget Neutrality Adjustment in the August 2006 Proposed Rule

In the August 2006 proposed rule, we presented an alternative approach to calculating the budget neutrality adjustment under the revised ASC payment system, which would take into account the effects of migration of procedures across ASCs, physicians' offices, and HOPDs that might be attributable to the revised ASC payment system (71 FR 49657 through 49658). In the following discussion, the phrase ''new ASC procedure'' refers to a surgical procedure not on the CY 2007 ASC list of covered surgical procedures but for which we proposed to make payment under the revised ASC payment system beginning in CY 2008.

Under this alternative, we assumed that 25 percent of the HOPD utilization for new ASC procedures would migrate to ASCs, and we also assumed that 15 percent of the physician's office utilization for new ASC procedures would migrate to ASCs in the first year of the revised ASC payment system. In the August 2006 proposed rule, we also noted our belief that our assumptions of 25 percent and 15 percent migration from HOPDs and physicians' offices to ASCs, respectively, were reasonable, given the general utilization relationships between those settings for services on the CY 2007 ASC list of covered surgical procedures. Services on the ASC list of covered surgical procedures that are predominantly performed in ASC and HOPD settings are, on average, performed 30 percent of the time in the ASC setting. Furthermore, services on the existing ASC list of covered surgical procedures that are mainly performed in ASC and physician's office settings are, on average, performed 17 percent of the time in the ASC setting. We assumed that new ASC procedures would migrate at slightly lower rates in the first year of the revised ASC payment system, yielding our migration assumptions to ASCs of 25 percent for the HOPD services and 15 percent for the physician's office services.

We also assumed that the net impact of migration of services on the existing CY 2007 ASC list of covered surgical procedures would be negligible. We noted that payment rates for the current highest volume ASC procedures would generally decrease under the proposed revised ASC payment system, and the lower volume ASC procedures would experience significant payment increases. We believed it was reasonable to assume that some of the higher volume services would migrate from ASCs to other settings, and some of the current lower volume procedures would migrate to the ASC setting as a result of the payment changes.

In order to calculate the budget neutrality adjustment under this alternative option in the August 2006 proposed rule, 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 rates were not revised and the ASC list of covered surgical procedures was not expanded, as described below.

a. Estimated Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Existing ASC Payment System in the August 2006 Proposed Rule

Step 1: Migration from HOPDs to ASCs was valued using estimated CY 2008 OPPS payment rates.

(a) We multiplied the estimated CY 2008 HOPD utilization for each new ASC procedure by 0.25, consistent with our assumption that 25 percent of the HOPD utilization for new ASC procedures would migrate to the ASC.

(b) For each new ASC procedure, we multiplied the results of Step 1(a) by the estimated CY 2008 OPPS payment rate for the procedure, and then subtracted beneficiary coinsurance for the procedure.

(c) We summed the results of Step 1(b) across all new ASC procedures.

Step 2: Migration of procedures from physicians' offices to ASCs was valued using estimated CY 2008 MPFS physician in-office payment rates. ''Physician in-office payment rate'' was equal to the MPFS nonfacility practice expense RVUs multiplied by the estimated CY 2008 MPFS conversion factor.

(a) To estimate the payment associated with our assumption that 15 percent of the physicians' office utilization for new ASC procedures would migrate to the ASC, we multiplied the projected CY 2008 physicians' office utilization for each new ASC procedure by 0.15.

(b) For each new ASC procedure, we multiplied the results of Step 2(a) by the estimated CY 2008 physician in-office payment rate for the procedure, and then subtracted beneficiary coinsurance for the procedure.

(c) We summed the results of Step 2(b) across all new ASC procedures.

Step 3: CY 2007 ASC services valued using the estimated CY 2008 ASC payment rates under the current ASC system.

This is described under Step 1 in the Estimated Payments under the Current ASC Payment System section, specifically section V.C.1.a. above.

Step 4: The results of Steps 1–3 were summed.

b. Estimated Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Proposed Revised ASC Payment System in the August 2006 Proposed Rule

Step 5: HOPD migration was valued using estimated CY 2008 OPPS payment rates.

This step is the same as Step 1 in section V.C.2.a. above.

Step 6: We identified new ASC procedures that were office-based (as discussed in section III.C. of this final rule).

Step 7: Migration of new ASC office-based procedures from physicians' offices to ASCs was valued based on estimated CY 2008 OPPS payment rates capped at the estimated CY 2008 physician in-office payment rates, if appropriate.

(a) For each new ASC procedure determined to be office-based, we multiplied the results of Step 2(a) from section V.C.2.a. above by the lesser of—

(1) The estimated CY 2008 OPPS payment rate for the procedure; or

(2) The estimated CY 2008 physician in-office payment rate for the procedure, and then subtracted beneficiary coinsurance for the procedure. (As noted in subsequent discussion in section V.C.3. of this final rule, we applied this adjustment for the capped office-based procedures after publication of the proposed rule and posted the results on our Web site.)

(b) The results of Step 7(a) were summed across all new ASC procedures considered to be office-based.

Step 8: Migration of new ASC procedures that were not determined to be office-based from physicians' offices to ASCs was valued using the estimated CY 2008 OPPS rates.

(a) For each new ASC procedure not considered to be office-based, we multiplied the results of Step 2(a) from section V.C.2.a. above by the estimated CY 2008 OPPS rate for the procedure, and then subtracted beneficiary coinsurance for the procedure.

(b) The results of Step 8(a) were summed across all new ASC procedures not considered to be office-based.

Step 9: Migration of new ASC procedures from physicians' offices to ASCs was valued using the estimated CY 2008 MPFS physician out-of-office payment rates. ''Physician out-of-office

payment rate'' was equal to the facility practice expense RVUs multiplied by the estimated CY 2008 MPFS conversion factor.

(a) For each new ASC procedure, we multiplied the results of Step 2(a) from section V.C.2.a. above by the estimated CY 2008 physician out-of-office payment rate for the procedure, and then subtracted beneficiary coinsurance for the procedure.

(b) The results of Step 9(a) were summed across all new ASC procedures.

Step 10: Current ASC services were valued using the estimated CY 2008 OPPS payment rates.

This is described under Step 2 in section V.C.1.b. above.

Step 11: The results of Steps 5 and 7–10 were summed.

c. Calculation of the Proposed CY 2008 Budget Neutrality Adjustment in the August 2006 Proposed Rule

Step 12: The result of Step 4 was divided by the result of Step 11.

Step 13: The calculation of the budget neutrality adjustment in Step 12 was calibrated in a number of ways. The application of the cap at the estimated CY 2008 MPFS nonfacility practice expense amount that occurred in Step 7 was dependent on the ASC conversion factor. The ASC budget neutrality adjustment resulting from Step 12 was calibrated to take into account the effects of the physician's office payment cap on the ASC conversion factor. The ASC budget neutrality calculation was also calibrated to take into account the fact that the additional physician out-of-office payments under the revised ASC payment system calculated in Step 9 must be fully offset by the budget neutrality adjustment to ASC services under the revised payment system. Furthermore, the budget neutrality calculation was calibrated to take into account the CY 2008 transitional payment rates for procedures on the CY 2007 ASC list of covered surgical procedures.

As reported in the August 2006 proposed rule (71 FR 49658), the budget neutrality adjustment calculated using this alternative option that incorporated CMS' migration assumptions was 0.62, indicating that under the migration assumptions described above there was no difference, rounded to the nearest hundredth, between our proposed budget neutrality adjustment without migration (0.62) and the alternative budget neutrality adjustment with migration (0.62).

d. Discussion of the Alternative Calculation of the Budget Neutrality Adjustment

We chose to propose calculation of the budget neutrality adjustment based on the CY 2007 final ASC list of covered surgical procedures and the most recent available ASC utilization data because we believed this was the most appropriate approach to estimating expenditures to result in a budget neutral payment system in CY 2008. We believed that the data available to us did not enable us to precisely estimate the net potential migration of services between the ASC, outpatient hospital, and physician's office settings that might result from implementation of the revised ASC payment system. Moreover, basing our estimate of expenditures on current ASC utilization without including migration from other sites of service was consistent with how we estimate expenditures for purposes of establishing budget neutrality in other Medicare payment systems. However, we recognized, that significant service migration would not generally be expected to occur under these other payment systems and acknowledged that the potential for migration could be significantly greater under the revised ASC payment system, with a possible effect on Medicare expenditures. Our recognition of the uniqueness of the revised ASC payment system was the reason we presented the alternative with-migration budget neutrality adjustment calculation in the August 2006 proposed rule, so commenters would have the opportunity to fully examine this model, in addition to the traditional without-migration methodology that we proposed to use.

Given that the revised ASC payment system includes a significant expansion of procedures for which ASC payment would be allowed, in addition to the expected service mix changes that result from the changes in payment incentives that accompany the introduction of any revised payment system, we expected that some commenters might believe that it would be more appropriate to estimate the ASC budget neutrality adjustment taking into account the potential migration of services between the ASC, hospital outpatient, and physician's office settings, consistent with the alternative with-migration model discussed in the August 2006 proposed rule. In that proposed rule, we explained that we would welcome data supporting the use of specific migration assumptions in the calculation of the ASC budget neutrality adjustment. We described the budget neutrality calculation under the alternative approach based on our best estimate of the potential migration of services between the different settings, hoping to facilitate and stimulate comment on migration that could occur and specifically to encourage the submission of pertinent quantitative evidence of service migration resulting from changes in payment rates. We welcomed data on all of the migration assumptions presented in the proposed rule discussion of the alternative approach. We noted that there was no difference between our proposed budget neutrality calculation without migration (0.62) and the alternative budget neutrality adjustment with migration (0.62), when rounded to the nearest hundredth.

Comment: Many commenters recommended different interpretations of section 626(b) of Public Law 108–173. The commenters believed that CMS' interpretation of the law's requirement that CMS ensure the budget neutrality of the revised system was overly restrictive and that consequently, the proposed budget neutrality factor was not adequate to make fair ASC payments. According to the commenters' interpretations of the law, they believed that CMS has the clear legal authority to make assumptions regarding the migration of procedures between different sites of service, and that expenditures for all services covered by the ASC payment system, including beneficiary coinsurance, should be considered in the calculation of budget neutrality. Most of the commenters recommended that CMS include projected case migration across ASC, HOPD, and physician's office settings in its budget neutrality model and use total expenditures across all Medicare Part B sites of service, rather than limit the base solely to estimated CY 2008 aggregate expenditures under the ASC payment system. Several commenters supported the use of the alternative option for calculating budget neutrality that incorporated the case migration assumptions as they were presented in the August 2006 proposed rule, with the stipulation that several technical corrections to fully account for the Medicare expenditures for all procedures that were assumed to migrate to the ASC would be made and that the resulting conversion factor would be 64.6 percent. Most other commenters believed that case migration would certainly be one result of implementation of the revised ASC payment system, and that CMS' budget neutrality adjustment model should include recognition of those changes in sites of service and the related Medicare expenditures. They recommended that

CMS use a model like the alternative option for calculating budget neutrality presented in the August 2006 proposed rule and discussed above in this final rule, but that the specific assumptions CMS used should be revised as indicated in their comments.

Response: As discussed in the August 2006 proposed rule, we were interested in comments from the public about our interpretation of budget neutrality and our proposed methodology for developing the budget neutrality adjustment factor for the revised ASC payment system. We will fully address each of the specific technical corrections (for example, that we account for differences in beneficiary coinsurance amounts in HOPD and ASC settings) and migration assumption modifications that were recommended by commenters in section V.C.3. of this final rule. At the more general level, we noted the strong preference among commenters for CMS to use the alternative, with-migration methodology that would take into account the effects of assumed migration of cases across ambulatory sites of service that could result from the payment changes associated with the revised ASC payment system. The August 2006 proposal reflected our belief that adoption of the without-migration model was more appropriate than the alternative with-migration model that was also discussed. In the proposal, we explained that basing our estimate of expenditures on current utilization without including migration from other sites of services was consistent with how we estimate expenditures for purposes of maintaining budget neutrality in other Medicare payment systems. We realized that the influx of newly covered procedures was unique to our proposal for the revised ASC payment system, but because the budget neutrality adjustment that resulted from both models in the August 2006 proposed rule was the same and data to determine estimates of potential case migration were limited, we adopted the without-migration model in our proposal, consistent with our previous modeling to ensure that our payment systems are budget neutral.

We agree with commenters that the flexibility to include migration assumptions in our calculation of budget neutrality for the revised ASC payment system is provided by the statute. Furthermore, our review of the extensive comments on the August 2006 proposed rule led to our conclusion in this final rule that the significant expansion of ASC covered surgical procedures proposed as part of the revised system is not only a unique aspect of the revised ASC payment system, but that its effects on ASC expenditures may be substantial. An influx of new covered services has not been a factor in developing the budget neutrality adjustment factors for our other prospective payment systems. The scope of services in other payment systems does not change significantly from one year to the next, as does the ASC scope of services between CYs 2007 and 2008 in the context of our final policies for the revised ASC payment system, as discussed in sections III. and IV. of this final rule.

In view of our belief that the revised ASC payment system is unique because of the significant expansion of covered surgical procedures and covered ancillary services to be paid under the revised ASC payment system, we conclude that including estimates of case migration of the new procedures, as well as the existing ASC covered surgical procedures, is the most accurate method for developing the budget neutrality adjustment in this case. After reviewing all of the public comments and reexamining the available data, we believe that there is sufficient evidence to indicate that adoption of a with-migration methodology for calculating the budget neutrality adjustment for the revised ASC payment system is appropriate. Thus, we have determined that it would be prudent, and more accurate, to adopt a with-migration budget neutrality estimation methodology, in order to take into account the effects of the migration of procedures between ASCs, physicians' offices, and HOPDs that might be attributable to the revised ASC payment system. While the budget neutrality estimation methodology that takes into account migration increases the complexity associated with establishing the budget neutrality adjustment, we believe that its application provides us with the most reasonable approach to establishing payment rates under the revised ASC payment system in order to assist in ensuring continued access to current ASC procedures and expanded access to new surgical procedures for Medicare beneficiaries in ASCs.

Although we are convinced that the with-migration model is more appropriate for calculating the final budget neutrality adjustment factor for the revised ASC payment system, we calculated the budget neutrality adjustment for this final rule using both with-migration and without-migration models, as we had for the August 2006 proposed rule. However, in contrast to the results of our work for that proposed rule, where application of either model resulted in the same adjustment factor, the budget neutrality factors that resulted from application of the two methods for this final rule were different. The adjustment factor that resulted from application of our proposed model that did not consider migration was 0.64, while the with-migration model resulted in a 0.67 budget neutrality adjustment factor. For a full discussion of the calculation of the final budget neutrality adjustment factor, we refer readers to section V.C.3. of this final rule.

Comment: Several commenters agreed with the use of a blended rate for CY 2008 to calculate budget neutrality for the revised ASC payment system, based on the proposal for a 2-year transition to the fully implemented revised payment system. They believed this use of discretion was an appropriate interpretation of the legislation and produced the most reasonable result. They believed that, because the proposed CY 2008 rates were a 50/50 blend of the CY 2007 ASC rate and the estimated CY 2008 ASC rate calculated according to the methodology of the proposed revised ASC payment system, the ASC payment system would have increased expenditures in CY 2009 unless migration patterns differed from the assumptions discussed in the proposed rule regarding the alternative calculation of the budget neutrality adjustment. These commenters concluded that the increased expenditures that would result from our adoption of their recommendation to utilize a modification of the alternative calculation of the proposed budget neutrality adjustment were expected, appropriate, and consistent with the budget neutrality provision of section 626(b) of Public Law 108–173 for the revised ASC payment system.

Response: We agree with commenters that the migration assumptions influence the relationship between estimated expenditures under the current ASC system and the revised ASC payment system over time. As noted elsewhere in sections IV.J. and V.C.4 of this final rule, we have extended the transition period for payment of services on the CY 2007 ASC list of covered surgical procedures and have also modified our migration assumptions to reflect migration over a more extended time period than was reflected in our discussion of the alternative option for calculating the budget neutrality adjustment in the August 2006 proposed rule. As described in section X. of this final rule, we estimate that, over time, the expenditures under the revised ASC system using our final migration assumptions would be slightly less than

the expenditures that would occur if we did not revise the system.

3. Calculation of the Estimated CY 2008 Budget Neutrality Adjustment According to the Final Policy

In the August 2006 proposed rule, and as discussed earlier in this section of the final rule, we described two methodologies for determining the budget neutrality adjustment under the revised ASC payment system that could then be used to establish the ASC conversion factor for CY 2008 (71 FR 49656 through 49658). We proposed that, under the standard methodology of the revised ASC payment system, the ASC conversion factor would be multiplied by the ASC payment weight for each covered surgical procedure to determine the procedure's CY 2008 ASC payment rate. As discussed in detail in section IV.C. of this final rule, our final policy will also provide separate payment for covered ancillary services under the revised ASC payment system. While the payment rates for separately payable drugs and biologicals, brachytherapy sources, corneal tissue acquisition, and implantable devices with OPPS pass-through status that are covered ancillary services, along with the device portion of ASC payment for device-intensive covered surgical procedures, will be determined without application of the ASC conversion factor, the final standard methodology of the revised ASC payment system will apply the ASC conversion factor to ASC payment weights to calculate the fully implemented payment rates for covered surgical procedures and covered ancillary radiology services. We received a number of general and specific comments on our proposal for calculating the CY 2008 ASC payment rates under the revised ASC payment system.

Comment: There was general agreement among the commenters that, in the absence of cost data for surgical procedures performed in ASCs, CMS' proposal to base the revised ASC payment system on the OPPS APC groups and their relative payment weights was sound policy that could reasonably be expected to result in accurate ASC payments for most procedures. Further, the commenters generally agreed that ASC facility costs are lower than the HOPD costs for providing the same surgical services. The commenters gave specific examples of the reasons why higher costs are incurred by hospitals, including the requirement that HOPDs satisfy quality and safety standards that are not applied to ASCs; the fact that hospitals' resources are available 24 hours a day, 7 days a week; Emergency Medical Treatment and Labor Act of 1986-related (EMTALA-related) requirements; treatment of a more acutely ill population with greater comorbidities; and higher uncompensated care rates. Moreover, those commenters cited MedPAC's findings reported in 2003 and 2004 that hospitals probably incur higher costs than ASCs for providing similar procedures, because HOPDs are subject to additional regulatory requirements which are likely to increase their overhead costs, and HOPDs also treat patients who are more medically complex.

Beyond these points, the commenters diverged on their opinions about the accuracy and appropriateness of the proposed conversion factor, as discussed in detail below.

Response: We appreciate the commenters' general support of our proposal to base payment under the revised ASC payment system on the OPPS relative payment weights and the APC groups. These comments were consistent with the recommendation of the GAO (GAO–07–86) that CMS should implement a payment system for procedures performed in ASCs based on the OPPS, taking into account the lower relative costs of procedures performed in ASCs compared to HOPDs. For further discussion of this subject, as well as a summary of additional public comments and our responses, we refer readers to section IV.B. of this final rule.

Comment: Several commenters specifically recommended that CMS adopt 75 percent as the multiplier to the OPPS conversion factor, so that payment rates under the revised ASC payment system would be 75 percent of the OPPS rates. They cited legislation that was introduced in the U.S. Senate in 2003 in which payments to ASCs were to have been provided at 75 percent of the OPPS rates. The proponents of that proposed legislation believed that, by using a 75 percent factor to reduce OPPS rates in order to provide payment for ASCs to perform procedures, Medicare would save 25 cents for every dollar spent for procedures performed in the ASC setting instead of the HOPD.

Several commenters also believed that, because ASC rates have been frozen since 2003 while OPPS rates have been increased annually for inflation, an unfair differential in payments between the two payment systems has grown over the past several years. These commenters argued that by calculating budget neutrality for the revised ASC payment system using the static ASC rates in comparison with annually updated OPPS rates, CMS proposed an inappropriately low budget neutrality adjustment factor. They were convinced that, if CMS had implemented the revised ASC payment system immediately after Congress passed Public Law 108–173 in 2003, before the differential between the payment rates for the two systems increased due to the continued freeze on ASC rates, the budget neutrality adjustment for the revised payment system would have been close to 85 percent, rather than 62 percent as CMS proposed for the revised payment system to be implemented in CY 2008. Other commenters, noting that Congress gave CMS the authority to implement the revised payment system between CY 2006 and CY 2008, expressed their belief that, had CMS implemented the revised ASC payment system in an earlier year, the budget neutrality adjustment would have been at least 8 percent higher than the 62 percent that was proposed.

Response: We see no rationale for estimating the budget neutrality adjustment by comparing existing ASC payment system rates with OPPS rates from an earlier calendar year, prior to implementation of the revised ASC payment system. Congress provided CMS with the latitude to implement the revised ASC payment system beginning on or after January 1, 2006, and not later than January 1, 2008. We believe that the statute provides direction that the revised ASC payment system is to be budget neutral in its design in order to result in the same aggregate expenditures for services as would be made if the provisions of the revised ASC payment system did not apply, that the ASC conversion factor is not to be updated before CY 2010, and that implementation of the revised system by January 1, 2008 is timely. There is no evidence that Congress intended for CMS to attempt to maintain the relationship between OPPS payment rates and ASC payments that existed at the time of enactment of Public Law 108–173 (CY 2003) in the development of the revised ASC payment system. We also see no rationale for adopting an arbitrary multiplier, such as 75 percent of OPPS payment rates, that is not founded on explicit consideration of budget neutrality as required by the statute.

We received many public comments in response to our proposed budget neutrality adjustment factor. A number of commenters included seven specific recommendations, three of which were related to the migration assumptions discussed as an alternative option for calculating the budget neutrality adjustment in the proposed rule. The

other four were technical in nature and related to our proposed budget neutrality model. A summary of the comments and our responses follow, beginning with the four recommended technical modifications to our proposed methodology, followed by the three migration assumption recommendations.

Comment: One of the recommended technical modifications was that, instead of basing ASC payments on CY 2007 rates for all procedures on the CY 2007 ASC list of covered surgical procedures, CMS should use the payment amounts that would be made in CY 2008 in the absence of the revised payment system for those ASC procedures whose payments are capped in CY 2007 due to section 5103 of Public Law 109–171. The commenters believed that using the lower CY 2007 rates for ASC procedures capped by section 5103 of Public Law 109–171 was an unfair representation of estimated ASC payments under the existing payment system in CY 2008. Their rationale was that, if the revised ASC system were not implemented in CY 2008, the payments for those services under the policy of the existing ASC payment system would increase in CY 2008, consistent with the overall projected increase in OPPS rates of 4 percent. The commenters expected that incorporation of this adjustment would result in a 0.11 percentage point increase to the budget neutrality adjustment.

Response: We do not agree that the ASC rates for these specific services would necessarily increase consistent with an overall increase in OPPS rates for CY 2008. Through the annual update of the OPPS, while the aggregate spending is generally projected to increase in the update, the specific payments for individual services may rise or fall from year to year based on a variety of factors, including APC recalibration. Because the ASC procedures that are capped at the OPPS rates in CY 2007 are a small subset of all OPPS services, we are unable to project that their rates would be subject to a 4 percent increase, or indeed any increase, as suggested by the commenters. In addition, we believe that Congress intended for the revised ASC payment system rates and budget neutrality to be related to the estimated aggregate expenditures for ASC services based on ASC payment rates from the year prior to implementation of the revised system. Congress mandated that the revised ASC system be budget neutral and be implemented by CY 2008. It also set ASC updates to zero percent for the calendar years through 2009. We believe all of those actions, in combination, provide clear indication that Congress did not intend for estimates of aggregate expenditures under the existing ASC payment system to take into account updated ASC payment rates for CY 2008. The limitations on ASC payments prior to implementation of the revised ASC payment system, specifically both section 626 of Public Law 108–173 that specifies that ASC rates would not be updated before CY 2010 and, further, the limit on ASC payment at the lesser of the OPPS or ASC rate, as required in section 5103 of Public Law 109–171 that extends until implementation of the revised ASC payment system, provide clear evidence that the CY 2007 ASC rates for covered procedures are to be used in developing the budget neutrality adjustment for the revised payment system. We continue to believe, for the purposes of this final rule, that the most appropriate course for calculation of the budget neutrality adjustment, consistent with our proposal, is to estimate that the CY 2008 rates for the ASC procedures subject to the cap set forth in section 5103 of Public Law 109–171 in CY 2007 will be the same as their CY 2007 rates.

Comment: Some commenters stated that, in CMS' calculation of estimated ASC payments under the existing ASC payment system for comparison to payments under the proposed methodology for the revised ASC payment system, CMS did not include payments for the costs of implantable prosthetic devices that are currently separately paid to ASCs under the DMEPOS fee schedule. The commenters recommended that CMS include the amount paid to ASCs to cover the costs of separately payable implantable prosthetics and DME under the DMEPOS fee schedule to avoid understating Medicare's current full cost related to the surgical implantation procedures. The commenters believed that inclusion of those payments would increase the budget neutrality adjustment by 0.41 percentage points.

Response: We agree with the commenters that the payments to ASCs for the implantable prosthetic devices and DME should be included in estimating total ASC payments for CY 2008 under the policies of the existing ASC payment system. In fact, we did include those payments in our proposed budget neutrality adjustment calculation, but we failed to explicitly state that in our explanation in the August 2006 proposed rule. Therefore, the effect of including those payments was reflected in the budget neutrality adjustment that we proposed. We have also included these payments in our calculation of the budget neutrality adjustment for this final rule.

Comment: Several commenters believed that, although CMS accounted for the 20 percent beneficiary coinsurance in ASCs by discounting by 20 percent all of the payment rates used to estimate the CY 2008 payments under the existing ASC system and under the proposed methodology of the revised ASC payment system, CMS did not appropriately account for beneficiary coinsurance associated with the new ASC office-based procedures for which payment was proposed to be limited to the MPFS unadjusted nonfacility practice expense amount. They believed that CMS should apply the 20 percent discount to those procedures because that approach would more accurately and consistently reflect the Medicare program costs, and they concluded that this change would increase the budget neutrality adjustment by 0.43 percentage points.

Response: While we did not apply this discount to payment rates for the capped office-based procedures newly proposed for ASC payment in CY 2008 in our calculation of the proposed budget neutrality adjustment, we agree with this recommendation. Recognizing those lower costs to the Medicare program, consistent with our calculation of program costs under the existing ASC payment system and the standard methodology of the revised ASC payment system, would be more accurate. Soon after publication of the August 2006 proposed rule, we discovered this oversight, made the appropriate adjustments to the data, and posted the revised data on our Web site (*http://www.cms.hhs.gov/ASCPayment*).

Comment: Commenters noted that CMS did not account for the variable copayment amounts associated with procedures under the OPPS for purposes of establishing the budget neutrality adjustment under the revised ASC payment system. The beneficiary copayment under the OPPS varies from 20 to 40 percent of the payment rate, depending on the procedure, whereas the coinsurance under the ASC payment system is 20 percent for all procedures. The commenters believed that as a result of not considering the sometimes much higher copayments under the OPPS, CMS artificially inflated Medicare's estimated payments under the proposed methodology of the revised ASC payment system. They believed that accurately accounting for the OPPS copayments would increase the budget neutrality adjustment by 1.04 percentage points.

Response: We agree with the commenters regarding this

recommendation. We did not apply the variable OPPS copayment amounts in the model that was proposed. However, soon after publication of the August 2006 proposed rule, we discovered this oversight, made the appropriate adjustments to the data, and posted the revised data on our Web site (*http://www.cms.hhs.gov/ASCPayment*).

After considering the first four technical recommendations of many commenters and making the two technical adjustments as described above, the resulting increase in the proposed budget neutrality adjustment was approximately 2.6 percentage points. We have applied these same two technical adjustments in our calculation of the budget neutrality adjustment for this final rule. In addition, we made another technical change in this final rule by taking the multiple procedure discount into account in our estimates of ASC, OPPS, and MPFS expenditures both before and after implementation of the revised ASC payment system. We factored the multiple procedure discount into our estimates of ASC, OPPS, and MPFS spending under the existing and revised ASC payment systems. We assumed that the pattern of multiple surgical procedures furnished in ASCs and physicians' offices would be similar to the pattern in HOPDs. Based on claims data indicating the prevalence of multiple procedures in HOPDs, we estimated the percentage of discounted units to total units for each procedure and then reduced the volume for those procedures prior to estimating expenditures in each year. We incorporated this reduction into our estimates of Medicare expenditures under the ASC, OPPS, and MPFS payment systems both before and after implementation of the revised ASC payment system. We had not factored the multiple procedure discount into the August 2006 proposed rule estimates.

The final three recommendations by commenters that were related to the migration assumptions used in the alternative option for calculating the budget neutrality adjustment presented in the August 2006 proposed rule are discussed below.

Comment: Many commenters believed that the alternative method for calculating the budget neutrality adjustment that CMS discussed in the August 2006 proposed rule described a preferable and superior method for developing the budget neutrality adjustment for the revised ASC payment system. They believed that developing and applying some assumptions to account for the migration of services and their payment across Medicare Part B sites of care would be the most appropriate method for ensuring budget neutrality. However, they recommended that CMS revise some of the assumptions regarding migration that were described in that proposed rule.

The first of their recommendations in this regard was that CMS use a much lower migration assumption of 2 percent for new ASC procedures migrating from physicians' offices to ASCs. They were convinced that CMS' assumption in the proposed rule that 15 percent of the current office utilization of new ASC procedures would migrate to ASCs was far greater than would be possible. They stated that ASCs do not have the capacity to absorb that level of services. Furthermore, they explained that ASCs have found that, once physicians acquire the equipment and resources to provide a procedure in their offices, they prefer to perform it there. The commenters believed that physicians only typically perform procedures in an ASC or HOPD setting when there is a particular patient need that requires the facility setting. They argued that by allowing the new ASC procedures to receive payment in ASCs, CMS would realize savings because cases could be moved from the office to an ASC instead of to the more costly HOPD setting when the physician determines that relocation of the service is preferable for a particular beneficiary.

Furthermore, the commenters stated that ASCs would not only be overwhelmed by the volume of cases CMS assumed would migrate to that setting, but that ASCs would not welcome the influx of low paying, minor procedures that could generally be performed in physicians' offices over the more complex, higher paying procedures that ASCs are accustomed to providing in the more efficient and intensive facility setting. The commenters believed that adjusting the assumption for migration of new ASC procedures from physicians' offices to ASCs to 2 percent of the cases would be more appropriate and would result in a 3.11 percentage point increase in the budget neutrality adjustment.

In addition, the commenters believed that CMS did not accurately adjust for the likely negative migration of cases involving procedures paid under the existing ASC payment system out of ASCs and into more costly HOPDs under the proposal for the revised payment system. They developed a model that they believed would more correctly predict the migration of procedures out of ASCs and into HOPDs based on the magnitude of the procedure's proposed payment rate decrease. In that model, the commenters assumed that for every 10 percent decrease in a procedure's ASC payment rate from the existing to the revised payment system, 1.5 percent of the ASC volume would migrate to HOPDs. They believed that CMS' application of this adjustment would result in a 0.51 percentage point decrease to the budget neutrality adjustment.

They also recommended that CMS account for the positive migration of existing ASC covered procedures from HOPDs to ASCs by assuming that for every 10 percent increase in a procedure's ASC payment rate under the proposal for the revised ASC payment system, 1.5 percent of the HOPD volume would migrate to ASCs, up to a maximum of 25 percent of the procedure's current HOPD volume. Furthermore, commenters suggested that ASC capacity would limit movement of these procedures to no more than 25 percent of each procedure's existing ASC volume. The commenters believed that, although ASCs have significant excess capacity, as confirmed by a CY 2006 industry study that showed that only about one quarter of ASCs were operating above 60 percent operating room capacity, they could not absorb more than 25 percent of the HOPD volume for all ASC procedures for which payment was expected to increase under the proposed revised payment system. They explained that application of their assumption would result in a 5.57 percentage point increase in the budget neutrality adjustment.

Response: We appreciate the extensive comments we received regarding the appropriate migration assumptions to be applied in determining the budget neutrality adjustment for the revised ASC payment system. While commenters provided a number of suggestions regarding migration assumptions for both the procedures on the CY 2007 ASC list of covered surgical procedures and new ASC procedures, they did not provide data supporting all of the specific assumptions regarding the relationship between expected service migration and changes in payment rates that they recommended we adopt along with their other migration assumptions. However, as stated above, we are adopting a with-migration model for calculation of the final budget neutrality adjustment factor because we believe that it is more accurate than the without-migration model that we proposed that does not consider the migration of new procedures across sites of service, but we did not adopt the assumptions recommended by some commenters.

The CMS Office of the Actuary (OACT) developed the assumptions utilized in the final budget neutrality model. With respect to current ASC covered surgical procedures paid under the existing ASC payment system, we did not accept the recommendation by commenters that we should assume that negative migration, that is, movement of existing ASC covered procedures out of ASCs and into the higher cost HOPD setting, would have an effect on our budget neutrality adjustment that is not equal to the effect of positive migration of cases from other settings into ASCs. Rather, in this final rule, after reviewing information provided by commenters and reevaluating current site-of-service utilization patterns for exiting and new ASC procedures, we are assuming that the effect on budget neutrality due to movement of cases involving existing ASC procedures out of ASCs will be balanced by movement of additional cases involving existing ASC procedures into ASCs. We believe that it is reasonable to assume that the payment increases for many currently low volume ASC procedures will result in higher ASC volumes for those procedures under the revised ASC payment system. Moreover, we believe that this anticipated positive migration of those procedures will balance the estimated negative migration of the high volume ASC procedures for which payment will decrease. Our actuaries project that the net budgetary effect of migration into and out of ASCs for procedures currently on the ASC list of covered surgical procedures will be negligible.

Consistent with our assumption for the alternative budget neutrality adjustment model discussed in the August 2006 proposed rule, under the final methodology for the revised ASC payment system, we assume that 25 percent of the current HOPD volume of new ASC procedures would ultimately migrate from HOPDs to ASCs. However, taking into consideration the final, longer 4-year transition period to the fully implemented payment weights of the revised ASC payment system and the final modifications to several aspects of the proposed payment policy as discussed in this preamble, for this final rule, we assume that the 25 percent case migration would occur more gradually, over the first 2 years of the transition, instead of all in the first year. We believe the migration would occur over the first 2 years of the 4-year transition, as the ASC industry adapts to the revised ASC payment system and the significant expansion of covered surgical procedures described in this final rule. We agree with commenters that the level of migration in a single year, as discussed in our presentation of the with-migration budget neutrality adjustment model in the August 2006 proposed rule, would be difficult for ASCs to accommodate in a single year, but we believe, based on current ASC and HOPD utilization and ASC industry information, that the 25 percent case migration over 2 years is most likely.

We believe that our assumption of 25 percent migration of current HOPD volume for new ASC procedures is reasonable, given the general utilization relationships between ASCs and HOPDs for services as discussed in section V.C.2. above. We also note that commenters generally did not disagree with our proposed HOPD migration assumption for the new ASC procedures. As discussed in the August 2006 proposed rule (71 FR 49657), services on the ASC list of covered surgical procedures that are predominantly performed in ASC and HOPD settings are, on average, performed 30 percent of the time in the ASC setting. Thus, for calculation of the budget neutrality adjustment according to the final policy of this final rule, we assume that new ASC procedures would migrate at the slightly slower rate of 25 percent over the first 2 years of the 4-year transition, reflecting their movement toward the general 30-percent site-of-service utilization pattern currently observed for ASC covered surgical procedures as ASCs transition to the revised ASC payment system.

Our assumed 25 percent migration of new ASC procedures from HOPDs to ASCs differs considerably from the commenters' recommended positive migration assumptions, because the commenters' model included all current ASC procedures and applied a formula linking the magnitude of ASC payment changes under the revised ASC payment system to the expected volume of migration. Given that the commenters based their estimate for this assumption on existing ASC procedures, they used 25 percent of current HOPD volume as the upper limit for migration from HOPDs to ASCs, the same assumption we used for the migration of new ASC procedures in CY 2008. However, because they believed that ASC capacity would ultimately limit procedure movement, they also limited the movement to 25 percent of the existing ASC volume for those procedures. Our actuaries determined migration assumptions separately for existing ASC covered procedures and new ASC procedures. As mentioned earlier, the net effect of migration of existing procedures into and out of ASCs is assumed to be negligible. For the new ASC procedures, it is assumed that 25 percent of the current HOPD volume will migrate to ASCs during the first 2 years of the revised ASC payment system.

The commenters assumed some negative migration of existing ASC covered procedures from ASCs to HOPDs in response to price changes under the revised ASC payment system, based on a relationship between a procedure's decrease in ASC payment and its volume of migration. However, as discussed above, we also believe that we have adequately accounted for the expected migration of procedures currently covered in ASCs from the ASC to the HOPD setting under the revised ASC payment system.

Finally, the commenters' recommendation that we assume much less migration from physicians' offices to ASCs for new ASC procedures due to ASC capacity limitations led us to reconsider our earlier assumption articulated in the August 2006 proposed rule for the alternative model to calculate the budget neutrality adjustment. Thus, for this final rule, although the actuaries' assumption is that 15 percent of the physicians' office volume of new ASC procedures may eventually be expected to move into ASCs, they did take into consideration the commenters' argument that such a level of migration could not be fully accommodated by ASCs in CY 2008. Therefore, in our final policy we assume that the migration of these currently office-based cases would occur more gradually, with an additional one quarter of the total migration occurring in each year of the full 4-year transition period. Thus, we expect that only 3.75 percent of the office utilization of new ASC procedures would migrate to ASCs in CY 2008, followed by an additional quarter of new cases in each subsequent year, reaching the full 15 percent by the end of the transition period to the fully implemented revised ASC payment rates. Given the current 17 percent ASC utilization of procedures that are predominantly performed in physicians' offices and ASCs that are on the existing ASC list of covered surgical procedures, we see no reason to assume that only 2 percent of the current office volume for new ASC procedures would migrate to ASCs, as suggested by some commenters. Instead, we believe the eventual utilization data for those procedures would most likely resemble the site-of-service utilization for procedures predominantly performed in ASC and physician's office settings that are currently paid in ASCs. Our

assumption of 15 percent is slightly lower than the current pattern of 17 percent ASC utilization, consistent with our expectation that migration of the broad array of new ASC procedures would result in slightly lower ASC utilization in 4 years than the currently observed pattern for procedures on the CY 2007 ASC list of covered surgical procedures that are predominantly performed in physicians' offices and ASCs.

In addition, in the context of developing the budget neutrality adjustment for the revised ASC payment system under the with-migration model, the actuaries took into consideration the final payment policies of the revised ASC payment system. These include the final changes to the payment rate calculations for device-intensive procedures, as well as the separate payment for covered ancillary services. While specific current and projected ASC utilization of covered ancillary services is difficult to estimate, in establishing the final budget neutrality adjustment, the actuaries took into account the findings of the GAO that payment for many of these ancillary services is currently provided to other Medicare Part B suppliers under the existing ASC payment system, and that most drugs and biologicals utilized with current ASC procedures do not receive separate payment under the OPPS.

In summary, since our discussion of the alternative model for calculating the budget neutrality adjustment presented in the August 2006 proposed rule for the revised ASC payment system, the actuaries have continued to refine the assumptions and estimates related to the with-migration budget neutrality model to take into account policy decisions made in this final rule, additional research, information from industry experts, and public comments. Application of our final revised migration assumptions, along with changes to the OPPS rates, MPFS rates, and updated utilization data, as well as the final payment policies for the revised ASC payment system, taken together result in an estimated budget neutrality adjustment of 0.67. The estimated budget neutrality adjustment of 0.67 in this July 2007 final rule for the revised ASC payment system is based on the CY 2007 OPPS relative payment weights, with an estimated update factor for CY 2008, the CY 2007 MPFS PE RVUs trended forward to CY 2008, and CY 2005 utilization data projected forward to CY 2008. It is important to note that the budget neutrality estimate in this final rule is illustrative only. The CY 2008 ASC budget neutrality adjustment will be proposed in the CY 2008 OPPS/ASC proposed rule based on the methodology for calculating budget neutrality established in this final rule and incorporating the proposed CY 2008 OPPS relative payment weights, the proposed CY 2008 MPFS PE RVUs, and CY 2006 utilization information projected forward to CY 2008. The final CY 2008 ASC budget neutrality adjustment will be established in the CY 2008 OPPS/ASC final rule with comment period. The final CY 2008 ASC budget neutrality factor will be calculated in that rule in accord with the methodology for calculating budget neutrality established in this July 2007 final rule and based on the final CY 2008 OPPS relative payment weights, the final CY 2008 MPFS PE RVUs, and updated CY 2006 utilization data projected forward to CY 2008.

4. Final Calculation of the Estimated ASC Payment Rates for CY 2008

The following is a step-by-step illustration of the final budget neutrality adjustment calculation.

a. Estimated CY 2008 Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Existing ASC Payment System

Step 1: Migration from HOPDs to ASCs is valued using estimated CY 2008 OPPS payment rates.

(a) We multiply the estimated CY 2008 HOPD utilization for each new ASC procedure by 0.125, consistent with our assumption that 25 percent of the HOPD utilization for new ASC procedures will migrate to the ASC over the first 2 years of the revised ASC payment system, only half of which would be in CY 2008. In estimating HOPD utilization for CY 2008, we take into account the impact of the multiple procedure discount (as discussed in more detail in section V.C.3. of this final rule).

(b) For each new ASC procedure, we multiply the results of Step 1(a) by the estimated CY 2008 OPPS payment rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(c) We sum the results of Step 1(b) across all new ASC procedures.

Step 2: Migration of procedures from physicians' offices to ASCs is valued using estimated CY 2008 physician in-office payment rates. ''Physician in-office payment rate'' is equal to the MPFS nonfacility practice expense RVUs multiplied by the estimated CY 2008 MPFS conversion factor.

(a) We multiply the estimated physician office utilization for CY 2008 for each new ASC procedure by 0.0375, consistent with our assumption that 15 percent of the physician's office utilization for new ASC procedures will migrate to the ASC over the full 4-year transition period.

(b) For each new ASC procedure, we multiply the results of Step 2(a) by the estimated CY 2008 physician in-office payment rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(c) We sum the results of Step 2(b) across all new ASC procedures.

Step 3: CY 2007 ASC services are valued using the estimated CY 2008 ASC payment rates under the current ASC system.

To estimate the aggregate expenditures that would be made in CY 2008 under the existing ASC payment system:

(a) We multiply the estimated CY 2008 ASC utilization for each HCPCS code on the CY 2007 ASC list by the estimated CY 2008 ASC payment rate for the HCPCS code under the existing ASC payment system, and then subtract beneficiary coinsurance for the procedure. The estimated CY 2008 ASC payment rates are based on the CY 2007 ASC payment rates, which were listed in Addendum AA to the CY 2007 OPPS/ASC final rule with comment period and take into account the OPPS cap on payment for ASC services as required by section 5103 of Public Law 109–171 and reflect the zero percent CY 2008 update for ASC services mandated by section 1833(i)(2)(C) of the Act. In estimating ASC utilization for CY 2008, we take into account the impact of the multiple procedure discount (as discussed in section V.C.3. of this final rule).

(b) We estimate the amount the Medicare program would pay in CY 2008 for implantable prosthetic devices and implantable DME for which ASCs currently receive separate payment under the DMEPOS fee schedule.

(c) We sum the results of Steps 3(a) and 3(b) to estimate the aggregate amount of expenditures that would be made in CY 2008 for current covered surgical procedures under the existing ASC payment system.

Step 4: Sum the results of Steps 1–3.

b. Estimated Medicare Program Payments (Excluding Beneficiary Coinsurance) Under the Revised ASC Payment System

Step 5: HOPD migration is valued using estimated CY 2008 OPPS payment rates.

This step is the same as Step 1, above.

Step 6: We identify new ASC procedures that are office-based (as discussed in section III.C. of this final rule).

Step 7: Migration of new ASC office-based procedures from physicians' offices to ASCs is valued based on estimated CY 2008 OPPS payment rates capped at the estimated CY 2008 physician in-office payment rates, if appropriate.

(a) For each new ASC procedure determined to be office-based, we multiply the results of Step 2(a) above by the lesser of—

(1) The estimated CY 2008 OPPS rate for the procedure; or

(2) The estimated CY 2008 physician in-office payment rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(b) The results of Step 7(a) are summed across all new ASC procedures considered to be office-based.

Step 8: Migration of new ASC procedures not determined to be office-based from physicians' offices to ASCs is valued using the estimated CY 2008 OPPS rates.

(a) For each new ASC procedure not considered to be office-based, we multiply the results of Step 2(a) above by the estimated CY 2008 OPPS rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(b) The results of Step 8(a) are summed across all new ASC procedures not considered to be office-based.

Step 9: Migration of new ASC procedures from physicians' offices to ASCs is valued using the estimated CY 2008 MPFS physician out-of-office payment rate. ''Physician out-of-office payment rate'' is equal to the facility practice expense RVUs multiplied by the estimated CY 2008 MFPS conversion factor.

(a) For each new ASC procedure, we multiply the results of Step 2(a) from above by the estimated CY 2008 physician out-of-office payment rate for the procedure, and then subtract beneficiary coinsurance for the procedure.

(b) The results of Step 9(a) are summed across all new ASC procedures.

Step 10: Current ASC services are valued using the estimated CY 2008 OPPS payment rates.

To estimate the aggregate amount of expenditures that would be made in CY 2008, we use estimated CY 2008 OPPS payment amounts instead of estimated CY 2008 ASC payment amounts under the current system, and we multiply the estimated CY 2008 ASC volume for each HCPCS code on the CY 2007 ASC list by the estimated CY 2008 OPPS payment rate for the HCPCS code, and then subtract beneficiary coinsurance for the procedure. We sum the results over all services on that ASC list.

Step 11: The results of Steps 5 and 7–10 are summed.

c. Calculation of the Final Estimated CY 2008 Budget Neutrality Adjustment

Step 12: The result of Step 4 is divided by the result of Step 11.

Step 13: The application of the cap at the estimated CY 2008 physician in-office payment rates that occurs in Step 7 is dependent on the ASC conversion factor. The ASC budget neutrality adjustment resulting from Step 12 is calibrated to take into account the interactive nature of the ASC conversion factor and the physician's office payment cap. The ASC budget neutrality calculation is also calibrated to take into account the fact that the additional physician out-of-office payment rates under the revised ASC payment system calculated in Step 9 must be fully offset by the budget neutrality adjustment to ASC services under the revised payment system. Furthermore, the budget neutrality calculation is calibrated to take into account the CY 2008 transitional payment rates for procedures on the CY 2007 ASC list of covered surgical procedures.

d. Calculation of the Final Estimated CY 2008 ASC Payment Rates

As described earlier, the application of the methodology to the data available for this final rule results in an estimated budget neutrality adjustment of 0.67. The CY 2008 budget neutrality adjustment for the revised ASC payment system, based on the methodology outlined above, will be proposed in the CY 2008 OPPS/ASC proposed rule and finalized in the CY 2008 OPPS/ASC final rule with comment period, based on the methodology for calculating budget neutrality established in this July 2007 final rule.

After developing the estimated CY 2008 budget neutrality adjustment of 0.67 according to the policies established in this final rule, in order to determine the estimated CY 2008 ASC conversion factor we multiply the estimated CY 2008 OPPS conversion factor by the budget neutrality adjustment. At this time, our estimate of the CY 2008 OPPS conversion factor is $63.497. Multiplying the estimated CY 2008 OPPS conversion factor by the 0.67 budget neutrality adjustment yields our estimated CY 2008 ASC conversion factor of $42.543 for this final rule. To determine the fully implemented ASC payment rates for this final rule, including beneficiary coinsurance, according to the final payment methodology that applies to covered surgical procedures and covered ancillary radiology services under the revised ASC payment system, we multiply the ASC conversion factor by the ASC relative payment weight for each procedure or service. As further discussed in sections IV.C. and IV.E. of this final rule, the ASC relative payment weights for certain office-based surgical procedures and covered ancillary radiology services are set so that the national unadjusted ASC payment rate does not exceed the MPFS unadjusted nonfacility practice expense amount. In addition, as discussed in section IV.C of this final rule, the ASC relative payment weights for device-intensive covered surgical procedures are set according to a modified payment methodology to ensure the same device payment under the revised ASC payment system as under the OPPS. We then calculate the estimated CY 2008 payment rate for procedures on the CY 2007 ASC list of covered surgical procedures using a blend of 75 percent of the final CY 2007 ASC payment rate and 25 percent of the estimated revised ASC payment rate developed according to methodology of the revised ASC payment system, applying the special transition treatment to device-intensive procedures as discussed in section IV.J. of this final rule. See Addenda AA and BB to this final rule for the illustrative estimated CY 2008 ASC payment weights and payment rates for covered surgical procedures and covered ancillary services that are expected to be paid separately under the CY 2008 revised ASC payment system.

D. Calculation of the ASC Payment Rates for CY 2009 and Future Years

1. Updating the ASC Relative Payment Weights

In the August 2006 proposed rule, we proposed to update the ASC relative payment weights each year using the national OPPS relative payment weights for that calendar year, as well as the practice expense payment amounts under the MPFS schedule for that calendar year because some covered office-based surgical procedures and covered ancillary services will be paid according to MPFS amounts if those are less than the rates calculated under the standard methodology of the revised ASC payment system. We further proposed to uniformly scale the ASC relative payment weights for each update year so that estimated aggregate expenditures using updated ASC relative payment weights would be the same as estimated aggregate expenditures using the current year ASC

relative payment weights. That is, we proposed to make the relative payment weights budget neutral to ensure that changes in the relative payment weights from year to year would not cause the estimated amount of expenditures to ASCs to increase or decrease as a function of those changes. For example, we proposed 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 would be the same as they would be using the CY 2008 ASC relative payment weights. Similarly, we proposed 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 would be the same as they would be using the CY 2009 ASC relative payment weights.

We proposed to scale the relative payment weights annually because we believed that the purpose of using relative payment weights as part of the ratesetting methodology under the proposed revised ASC payment system was only to establish appropriate relativity among surgical procedures paid in ASCs. Changes in weights should not, in and of themselves, change aggregate payment levels under a prospective payment system. 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 outpatient hospital emergency or clinic visits relative to outpatient hospital surgical costs. Moreover, making the ASC relative weights budget neutral would shield the ASC payment system from the inadvertent impact of unrelated aggregate changes in OPPS expenditures. We proposed to continue this methodology to update the revised ASC payment system in future years.

Comment: Several commenters supported the proposal to annually update ASC relative payment weights using the national OPPS payment weights for the corresponding year; conversely, some commenters also expressed concern regarding our proposed policy of rescaling ASC relative weights. They were concerned that annual rescaling would cause divergence of the relative weights between the OPPS and the revised ASC payment system for individual procedures.

Response: We appreciate commenters' support for annually updating ASC relative payment weights in coordination with the OPPS update, consistent with the proposed relationship between the two payment systems. We believe this process would provide more appropriate payments for surgical services under the revised ASC payment system that would reflect ongoing changes in the facility costs associated with different surgical procedures. We also acknowledge commenters' concerns about our proposed policy of rescaling ASC relative weights. However, we note that rescaling the relative payment weights in the ASC payment system would not cause divergence in the relativity of the weights of various services under the two payment systems. Rescaling of the weights would equally increase or decrease the relative payment weights of services under the revised ASC payment system in comparison to the relative weights of the same services under the OPPS, but only to the extent necessary to ensure that changes in the relative weights do not, in and of themselves, change aggregate payments to ASCs.

Rescaling of relative weights or the application of a budget neutrality adjustment is a common feature of Medicare payment systems, designed to ensure that the estimated aggregate payments under a payment system for an upcoming year would be neither greater than nor less than the aggregate payments that would be made in the prior year, taking into consideration any changes or recalibrations for the upcoming year. For example, in CY 2006, as required by section 1833(t)(9)(B) of the Act, we scaled relative weights under the OPPS by applying a budget neutrality adjustment to ensure that changes due to APC reclassification and recalibration changes, wage index changes, and other adjustments were made in a manner that ensured that estimated aggregate OPPS payments for CY 2006 would not exceed aggregate payments for CY 2005 (70 FR 68542). We continue to believe that this principle should apply as well in the revised ASC payment system. We note that while we do not currently have a provider-level dataset of ASC utilization that accurately identifies unique ASCs and their geographic information that would allow us to compare changes in geographic adjustment over time for budget neutrality purposes, we intend to take these changes into account in maintaining budget neutrality for the revised ASC payment system as soon as our provider-level ASC data permit.

In addition to considerations that are common to many payment systems, there is another reason for adopting annual rescaling of the relative weights in the revised ASC payment system. Because we are finalizing our proposal to generally employ the relative payment weights developed under the OPPS in the revised ASC payment system as discussed earlier in section IV.B. of this final rule, aggregate payments to ASCs could, in the absence of rescaling, be affected by changes in the cost structure of HOPDs that ought to be relevant only under the OPPS. We provided an example of such a scenario in the August 2006 proposed rule. A sudden increase in the costs of hospital outpatient emergency or clinic visits due, for instance, to an increase in the volume of cases, would have the effect of increasing the weights for these services relative to the weights for surgical procedures in the hospital outpatient setting. In the absence of rescaling, this change in the relative weights under the OPPS would result in a decrease in the relative weights for surgical procedures under the ASC payment system and, therefore, a decrease in aggregate ASC payments for these same procedures. Because ASCs principally receive payment for surgical procedures, aggregate payments to ASCs could decline; ASCs would receive lower payments for surgical procedures without realizing the benefits of the higher payments provided to HOPDs for emergency or clinic visits. As we explained in the August 2006 proposed rule (71 FR 49657), we believe that changes in relative weights each year under the OPPS should not, in and of themselves, cause aggregate payments under the revised ASC payment system to increase or decrease. In fact, scaling the relative weights each year under the revised ASC payment system would serve as a buffer to protect ASCs from sudden changes that could occur under the OPPS.

Rescaling of relative payment weights in a budget neutral manner under the revised ASC payment system would thus shield the ASC payment system from the inadvertent impact of unrelated aggregate changes in OPPS expenditures. It is important to note that the specific adjustment factor applied in the scaling process could be positive or negative in any particular year. Annual scaling would prevent both sudden decreases in aggregate payments to ASCs and sudden windfall payments due solely to changes in HOPD costs for nonsurgical services. In the example given above, the scaling adjustment would be positive, that is, scaling would increase the relative weights of all surgical procedures under the ASC payment system in order to maintain aggregate ASC payments for the

procedures at the same level, in the absence of other factors affecting the relative payment weights of hospital outpatient emergency or clinic visits and surgical procedures under the OPPS.

After considering the public comments we received, we are finalizing our proposal, without modification, to update the ASC relative payment weights in the revised ASC payment system each year using the national OPPS relative payment weights for that same calendar year and to uniformly scale the ASC relative payment weights for each update year to make them budget neutral. For example, holding ASC utilization and the mix of services constant, for CY 2009, we will compare the total weight using the CY 2008 ASC relative payment weights under the 75/25 blend (of the CY 2007 payment rate and the revised payment rate) with the total weight using CY 2009 relative payment weights under the 50/50 blend (of the CY 2007 payment rate and the revised payment rate), taking into account the changes in the OPPS relative payment weights between CY 2008 and CY 2009. We will use the ratio of CY 2008 to CY 2009 total weight to scale the ASC relative payment weights for CY 2009. Scaling of ASC relative payment weights would apply to covered surgical procedures and covered ancillary radiology services whose payment rates are related to OPPS relative payment weights. Scaling would not apply in the case of ASC payment for other separately payable covered ancillary services that have a predetermined national payment amount (that is, their national payment amounts are not based on OPPS relative payment weights) such as drugs and biologicals that are separately paid under the OPPS. Any service with a predetermined national payment amount would be included in the budget neutrality comparison, but scaling of the relative payment weights would not apply to those services that have a predetermined payment amount. The ASC payment weights for those services without predetermined national payment amounts (that is, their national payment amounts would be based on OPPS relative payment weights if a payment limitation did not apply) would be scaled to eliminate any difference in the total payment weight between the current year and the update year.

2. Updating the ASC Conversion Factor

Section 1833(i)(2)(C) of the Act requires that, if the Secretary has not updated the ASC payment amounts in a calendar year after CY 2009, the payment amounts shall be increased by the percentage increase in the CPI–U as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved. Therefore, in the August 2006 proposed rule for the revised ASC payment system we proposed to update the ASC conversion factor using the CPI–U in order to adjust ASC payment rates for inflation.

We received a number of comments regarding our proposal to use the CPI–U to adjust payments to ASCs for inflation, and these comments and our responses are discussed in section IV.H. of this final rule, which addresses the adjustment for inflation under the revised ASC payment system. We did not receive any public comments regarding our proposal to adjust ASC payments for inflation by applying the inflation adjustment to the conversion factor under the revised ASC payment system.

As explained in section IV.H. of this final rule, after consideration of the public comments we received, we are finalizing our proposal under §§ 416.171(a) and (b), without modification, to apply the CPI–U to adjust payments to ASCs for inflation. We will implement the annual update through an adjustment to the conversion factor under the revised ASC payment system, beginning in CY 2010 when the statutory requirement for a zero update no longer applies.

E. Annual Updates

Currently, under the existing ASC payment system, we update the ASC list of covered surgical procedures every 2 years through the notice and comment regulation process. We make additions to and deletions from the ASC list of covered surgical procedures based on clinical judgment and data that are available regarding utilization of care settings. We last published an updated list of the ASC covered surgical procedures in the CY 2007 OPPS/ASC final rule with comment period (71 FR 67960).

Under the revised ASC payment system, which will be implemented effective January 1, 2008, we proposed in the August 2006 proposed rule 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 payment rate. To the extent possible under the rules and policies of the revised ASC payment system, we proposed to maintain consistency between the OPPS and the ASC payment system in the way we treat new and revised HCPCS and CPT codes for payment under the ASC payment system. We also proposed 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 proposed to update the ASC list of covered surgical procedures and payment system as part of the annual proposed and final rulemaking cycle updating the hospital OPPS. We believed 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 covered surgical procedures for which Medicare makes payment to ASCs 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 August 2006 proposed rule for the revised ASC payment system, we proposed to issue a final rule in the first part of CY 2007 in which we would respond to comments submitted timely regarding the proposals set forth in that proposed rule and make final the policy and regulations for the revised ASC payment system for implementation effective January 1, 2008. We also proposed to include the CY 2008 ASC payment rates for surgical procedures payable in an ASC as part of the proposed and final rules for the CY 2008 OPPS update.

In addition, in the August 2006 proposed rule we proposed to evaluate each year all new HCPCS codes that describe surgical procedures to make preliminary determinations regarding whether or not they should be payable in the ASC setting and, if so, whether they are office-based procedures. In the absence of claims data that would indicate where procedures described by new codes are being performed and identify the facility resources required to perform them, we proposed to use other available information, including our clinical advisors' judgment, predecessor CPT and Level II HCPCS codes, information submitted by representatives of specialty societies and professional associations, and information submitted by commenters during the public comment period following publication of the final rule with comment period in the **Federal Register**. We 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. The ASC payment system treatment of those procedures would be open to comment on that final rule, and we would respond to comments about our interim 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 a new code was that it should reside on the ASC list of covered surgical procedures as an office-based procedure subject to the payment limitation, this determination would remain preliminary until we were able to consider more recent volume and utilization data for each individual procedure code and/or, if appropriate, the clinical characteristics, utilization, and volume of related codes. Using that information, if we confirmed our determination that the new code was appropriately assigned to an office-based payment indicator, it would then be permanently assigned to the list of office-based procedures subject to the payment limitation.

Accordingly, we proposed to reflect this annual rulemaking and publication of revised payment methodologies and payment rates in new § 416.173 in proposed new Subpart F.

Comment: Several commenters recommended that CMS continue to consider the input of interested parties submitting comments regarding the assignment of HCPCS codes to appropriate APCs, additions to and deletions from the ASC list of covered surgical procedures, and creation of payment mechanisms to account for new technology.

Response: As stated in our August 2006 proposal for the annual update process, we intend to invite comments from interested parties as part of the consolidated annual update cycle for updating the hospital OPPS and revised ASC payment system. As always, the OPPS treatment, including APC assignments, of all HCPCS codes would be open to comment, and we proposed also to invite comment regarding whether 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. This approach is consistent with the recommendation of the PPAC that we utilize a process for the revised ASC payment system to obtain input from national medical specialty societies and the ASC community in order to provide payment to ASCs for all safe and appropriate procedures and to allow for changes in technology and evolution in medical practice. Annual updating will provide for the adaptable methodology that the PPAC recommends for the revised ASC payment system.

Comment: Some commenters supported our proposal for the annual updates, indicating that the proposed alignment of annual updates to the revised ASC payment system with the OPPS updates is appropriate and allows the industry to review and contemplate the changes in both payment systems simultaneously.

Response: We appreciate the commenters' support and continue to 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 ASCs 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. We believe this approach is especially appropriate, given the final policy of the revised ASC payment system as discussed further in section IV.B. of this final rule, to use the APC groups and 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 paid in ASCs beginning in CY 2008. The annually updated OPPS device offset percents will be used to establish ASC payment rates for device-intensive procedures. In addition, according to the final policies established in this final rule, the OPPS relative payment weights and rates will be used as the basis for the payment of most covered ancillary services under the revised ASC payment system, so coordinated annual updating of the OPPS and the revised ASC payment system is particularly important.

Comment: A number of commenters indicated that many ASCs were interested in submitting bills to Medicare using the same claim form that is used by HOPDs, the CMS UB–92 (soon to be the UB–04), so that CMS would have additional information available for the annual ASC update under the revised ASC payment system. The commenters stated that the CMS–1500 billing form currently used by most Medicare Part B providers and suppliers, including ASCs, limits the amount of information that ASCs can report on claims. The commenters expressed concern that, as a result of having to use the CMS–1500, the true costs incurred by ASCs to provide services are not available to CMS and that, consequently, CMS cannot include actual ASC costs in its analyses to develop and update the revised payment system. They recommended that ASCs be allowed to report to CMS the same level of detail about the services they provide as do HOPDs. Further, the commenters stated that it would be less burdensome than the current Medicare billing policy because ASCs already use the UB–92 to submit bills to commercial payors. Thus, they concluded that allowing ASCs to use the UB–92 for Medicare Part B billing would be advantageous for both CMS and ASCs, because ASCs could provide more detailed cost information to CMS and this change would reduce the administrative burden on ASCs that currently are maintaining billing capabilities for both the CMS–1500 and UB–92 formats.

Response: For future ASC update years, we will explore the feasibility of adopting the ASC billing change recommended by commenters, but this is not a change that we can make by January 2008. We understand the commenters' concerns in this regard and investigated the possibility of implementing this recommendation as part of the revised payment system, effective January 2008. A policy change that requires ASCs to use a different billing format would have to incorporate adequate time for CMS and ASCs to make the necessary systems changes and for CMS to provide training for contractors and ASCs prior to implementing the new format. Although we will continue to explore this recommendation, not only is there insufficient time to make systems changes and provide training before implementation of the revised ASC payment system, but CMS is in the midst of a comprehensive reorganization of its contracting functions, making adoption of any significant billing change at this time even more challenging. During the next few years, Medicare Part A and B claims will be processed by reconfigured contracting entities, and we believe that allowing ASCs to bill using the same format as HOPDs should be explored as part of that larger contractor reform. We plan to pursue the feasibility of this option and to coordinate any possible change to ASC billing requirements with CMS' overall contracting transition. We welcome additional information from the public regarding recommendations for ASC billing

modifications or improvements that we should consider once the revised payment system is implemented. We note that, under our final annual update methodology for the revised ASC payment system, we would not require ASC information beyond that currently available to us through the CMS–1500 in order to annually update the ASC payment system.

After consideration of the public comments we received, we are finalizing our proposal as reflected in § 416.173, without modification, to annually update the ASC conversion factor, the relative payment weights and OPPS APC assignments of covered surgical procedures paid in ASCs, the ASC payment rates, and the list of surgical procedures for which Medicare would not make payment to ASCs as part of the annual proposed and final rulemaking cycle updating the hospital OPPS. In addition, we will annually update the list of covered ancillary services and their ASC payment rates. We also are finalizing our proposal, without modification, to evaluate each year all new HCPCS codes that describe surgical procedures to make preliminary determinations regarding whether they should be payable in the ASC setting and, if so, whether they are office-based procedures. The ASC treatment of these procedures would be open to comment in the final rule, and we would provide responses in the final rule for the following calendar year. Designations of new surgical procedure codes as office-based would remain preliminary until there are adequate physicians' claims data to assess their predominant sites of services, whereupon if we confirm their office-based nature, the codes would be permanently assigned to the list of office-based procedures subject to the ASC payment limitation.

VI. Information in Addenda Related to the Revised CY 2008 ASC Payment System

We include addenda to the preamble of proposed and final rules updating the ASC payment system to present national ASC unadjusted payment rates, by HCPCS code, and other factors that affect ratesetting. For example, in Addendum BB to the August 2006 proposed rule for the revised ASC payment system, we listed the HCPCS codes of surgical procedures for which we proposed to allow payment to ASCs in CY 2008, the short descriptors for those codes, and whether or not the code was proposed to be newly added to the list of covered surgical procedures. We also indicated for each HCPCS code: (1) Whether or not we proposed to designate it as office-based; (2) whether or not we proposed to cap it at the MPFS nonfacility practice expense rate; (3) the estimated proposed CY 2008 ASC relative payment weight; (4) the estimated proposed CY 2008 full payment and coinsurance amounts; and (5) the estimated proposed CY 2008 transitional payment and coinsurance amounts using a 50/50 blend of the current and proposed new rates. Addendum CC to the August 2006 proposed rule listed the specific subset of HCPCS codes and their short descriptors for procedures proposed for payment limitation at the MPFS nonfacility practice expense amount under the revised ASC payment system.

We will continue to use addenda to summarize, as part of the annual proposed and final OPPS/ASC rules updating both payment systems, the annual update of the relative payment weights of ASC covered surgical procedures, the national unadjusted ASC payment amounts for those procedures, the procedures designated as office-based that are subject to payment limitation at the MPFS nonfacility practice expense amount, and other pertinent information that bears on the determination of the payment status and payment rates for services under the revised ASC payment system for the update year. We will also summarize in the addenda the covered ancillary services that will be separately paid under the revised ASC payment system if they are integral to the performance of a covered surgical procedure, including their updated relative payment weights as appropriate, the national unadjusted ASC payment amounts for those services, and other pertinent information.

Although we are including addenda to this final rule, we emphasize that the information presented in these addenda is intended solely to demonstrate the payment rates that result from application of the revised ASC payment system methodology that we are finalizing in this final rule based on the most current data available. We caution readers that the illustrative relative payment weights, national payment amounts, and other information shown in the addenda to this final rule are neither the proposed nor final ASC rates for the CY 2008 revised ASC payment system. The information in the addenda to this final rule exemplifies the results of applying the revised ASC payment system methodology implemented in this final rule to the final or most recently updated CY 2007 OPPS information, with application of the estimated CY 2008 OPPS update, including the CY 2007 APC groupings and relative payment weights, the CY 2007 second quarter OPPS payment rates for drugs and biologicals, the CY 2007 OPPS payment methodology for brachytherapy sources, the specification of surgical procedures as subject to OPPS multiple procedure discounting, the designation of surgical procedures as inpatient only under the OPPS, the identification of surgical procedures for which payment is packaged under the OPPS rather than separately paid, and the CY 2007 OPPS device-dependent APCs and their respective device offset percents. The information is also based on the most recently available Part B utilization data derived from the full year of CY 2005 ASC and physicians' claims, and the CY 2008 estimated transitional nonfacility practice expense payment amounts for the CY 2008 MPFS, with application of the projected CY 2008 MPFS update.

We reiterate that the information in the addenda to this final rule does not represent the rates that we will be proposing for implementation in CY 2008 under the revised ASC payment system, but merely serves to illustrate application of the final ratesetting methodology under the revised ASC payment system. All information included in Addendum AA and Addendum BB to this final rule is subject to change in the annual cycle of notice and comment rulemaking to update the OPPS/ASC payment rates for CY 2008, with the exception of the office-based designation of procedures whose designation is not marked as temporary. We note that we have also included in Addenda AA and BB to this final rule HCPCS codes for those surgical procedures, radiology services, implantable devices, and drugs and biologicals whose payment is packaged under the OPPS and which, therefore, would not be eligible for separate ASC payment as covered surgical procedures or covered ancillary services, in order to facilitate review of the ASC payment policies for these groups of services. Payment to ASCs under the revised ASC payment system for these services would also be packaged. We will propose the relative payment weights, payments rates, and other pertinent ratesetting information for the CY 2008 revised ASC payment system in the OPPS/ASC proposed rule to update both payment systems for CY 2008. This proposed rule will be issued in mid-summer of CY 2007. The relative payment weights and payment rates and other pertinent ratesetting information proposed for the revised ASC payment system in CY 2008 will be based on proposed CY 2008 OPPS payment weights and APC groups, proposed CY

2008 MPFS nonfacility practice expense payment amounts, CY 2007 second quarter OPPS payment rates for drugs and biologicals as established based on the ASP information for that quarter, and the most recent Part B utilization data available to us from CY 2006 claims.

CMS will publish final relative payment weights and final payment rates and other pertinent ratesetting information for the CY 2008 revised ASC payment system in the final OPPS/ASC rule that updates both payment systems for CY 2008.

Changes in CY 2008 payments for physicians' services under the MPFS, in first quarter CY 2008 prices for drugs and biologicals based on the most recent available ASP data, and in CY 2008 HCPCS codes and pricing of OPPS services that may occur and that would affect the CY 2008 revised ASC payment system between publication of the CY 2008 OPPS/ASC final rule and release of the January 2008 OPPS PRICER and the ASC payment files will be reflected in updated addenda that we will post on the CMS Web site.

We have created Addendum DD1 to this final rule to define ASC payment indicators that we will use in Addenda AA and BB to provide payment information regarding covered surgical procedures and covered ancillary services, respectively, under the revised ASC payment system. Analogous to the OPPS payment status indicators that we publish in Addendum D1 as part of the annual OPPS rulemaking cycle, the ASC payment indicators in Addendum DD1 are intended to capture policy-relevant characteristics of HCPCS codes that may receive packaged or separate payment in ASCs, including their ASC payment status prior to CY 2008; their designation as device-intensive; their designation as office-based and the corresponding ASC payment methodology; and their classification as a separately payable radiology service, brachytherapy source, OPPS pass-through device, corneal tissue acquisition service, drug or biological, or NTIOL.

VII. ASC Regulatory Changes

In the August 23, 2006 proposed rule, we proposed to modify applicable ASC regulations under 42 CFR Parts 410, 414, and 416 to incorporate the requirements and conditions for payments for ASC facility services under the revised payment system that was proposed for implementation beginning January 1, 2008.

A. Regulatory Changes That Were Finalized in the CY 2007 OPPS/ASC Final Rule With Comment Period

In the August 23, 2006 proposed rule (71 FR 49631), we proposed the following regulatory changes which we finalized in the CY 2007 OPPS/ASC final rule with comment period (71 FR 68174).

- We proposed to revise the current regulations at Part 416, Subparts D and E, to ensure that the rules governing the current ASC payment system are clearly distinguishable from those that would apply to the revised system beginning January 1, 2008.
- We proposed to revise Subparts D and E to Part 416 to reflect the rules governing the ASC payment system prior to January 1, 2008.
- We proposed to redesignate existing Subpart F as Subpart G under Part 416 to codify the rules governing the ASC payment adjustment for NTIOLs (71 FR 49631).
- We proposed several technical changes to Part 416 (71 FR 49659).
- We proposed to revise existing § 416.1 (Basis and scope) to remove the obsolete reference to ''a hospital outpatient department,'' and to add provisions of section 5103 of Public Law 109–171 and applicable provisions of Public Law 108–173.
- We proposed to revise existing § 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 proposed to remove the obsolete cross-reference in paragraph (a)(4) to § 405.310 and replace it with the correct cross-reference to § 411.15.
- We proposed to revise § 416.125 (ASC facility services payment rate) to incorporate the limitation on payment imposed by section 5103 of Public Law 109–171.
- We proposed to revise § 488.1 (Definitions) to add ambulatory surgical centers to the definition of a supplier in conformance with section 1861(d) of the Act.
- We proposed to add new § 416.76 and new § 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.

The bases for these proposed regulatory changes were discussed in detail throughout the preamble of the August 23, 2006 proposed rule. We did not receive any public comments on these proposed revisions. In the CY 2007 OPPS/ASC final rule with comment period, we made these provisions final as proposed, without modification (71 FR 68174).

B. Regulatory Changes Included in This Final Rule

In the August 23, 2006 proposed rule (71 FR 49699), we proposed to add a new Subpart F to Part 416 entitled ''Subpart—Coverage, Scope of ASC Facility Services, and Prospective Payment System for Facility Services Furnished On or After January 1, 2008,'' which would include the following new sections:

§ 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.

We also proposed a technical change to 42 CFR Part 414 to conform with changes we were proposing under Part 416, new Subpart F (71 FR 49659), and we likewise proposed to revise § 410.152(i) to make it consistent with provisions of the revised ASC payment system. The numerous public comments that we received regarding the revised ASC payment system we proposed to implement January 1, 2008, are addressed in detail throughout the preamble of this final rule.

As a result of our review of the public comments, in this final rule, we have made a number of modifications to our proposals for the revised ASC payment system. These modifications, which are also discussed in detail in other sections of this final rule, have necessitated corresponding changes in the regulations that we proposed for the revised ASC payment system. The following is a summary of changes to 42 CFR 410 and 416 that reflect those modifications, which we are finalizing in this final rule.

- We added a new paragraph (i)(2) under § 410.152 to specify the amount of payment the Medicare program makes for ASC services beginning January 1, 2008.
- We decided not to finalize the proposed revision of § 414.22(b)(5)(i)(B) in this final rule.
- In § 416.2, we revised the definitions of ''ASC services,'' ''Covered surgical procedures,'' and ''Facility

services,'' and we added a definition of ''Covered ancillary services.''

• We added new Subpart F, as proposed, but modified the title to read ''Coverage, Scope of ASC Services, and Prospective Payment System for ASC Services Furnished on or after January 1, 2008.'' We also modified certain proposed sections under Subpart F and added other provisions as outlined below.

• We revised the section headings of §§ 416.161 and 416.164 to read ''Applicability of this subpart'' and ''Scope of ASC services,'' respectively.

We also revised the section heading of § 416.171 to read ''Determination of payment rates for ASC services.'' In addition, we added new § 416.179 with a new section heading.

• We added § 416.160(a)(4), which addresses payment rules for screening flexible sigmoidoscopy and screening colonoscopy services. Also, we reordered the paragraphs of § 416.160.

• We revised § 416.160(b) to conform the text with the changes to the definitions in § 416.2.

• We made a technical change to §§ 416.163(b) and (c) to specify that payment for anesthetists' services is made in accordance with 42 CFR part 414, in addition to editorial changes to § 416.163(a) to reference ASC services rather than ASC facility services.

• We revised § 416.164(a), ''Included facility services,'' and we renamed and revised § 416.164(b) as ''Covered ancillary services,'' to reflect the policy regarding the packaging of services which is made final in section IV.C. of this final rule. Proposed § 416.164(b) becomes final § 416.164(c), ''Excluded services,'' where we revised anesthetists' services, which are paid under 42 CFR part 414 and where we changed x-ray procedures to radiology services and separated diagnostic procedures and radiology services into separate items. Also, ''Excluded services'' no longer includes costs incurred to procure corneal tissue.

• In § 416.166(c), ''General exclusions,'' we deleted the phrase ''other medical procedures'' from the introductory sentence to conform with the definition of the type of procedures covered under the ASC benefit as discussed in section III. of this final rule. We moved the criterion proposed as paragraph (c)(5) (regarding the expected requirement for active medical monitoring and care at midnight following the procedure) to § 416.166(b) as an element of the ''General standards.'' We also added the following as new criteria for exclusion of a procedure from coverage when performed in an ASC: (1) Commonly require systemic thrombolytic therapy; (2) are designated as requiring inpatient care under § 419.22(n); and (3) can only be reported using a CPT unlisted surgical procedure code.

• We made technical and editorial changes to § 416.167(a) and (b) to reference payment for ASC services and covered ancillary services.

• We revised § 416.171 to reflect the modifications that we are making final in this final rule regarding separate payment for certain covered ancillary services and the extension of transitional payment rates from 1 to 3 years, as discussed in section IV. J. of this final rule.

• We revised § 416.172 as follows: (1) Made minor changes to paragraphs (a), (b), (d), and (e) to reference ASC services and to clarify that the comparison for purposes of assessing the lesser of the actual charge or the prospective rate is to the geographically adjusted payment rate; and (2) revised paragraph (c) to exclude application of a geographic adjustment to payment rates for certain drugs, devices, and brachytherapy sources, as discussed in section IV. C. of this final rule. In addition, we added new paragraph (f) to reflect the payment adjustment when ASC services are interrupted due to circumstances that threaten the well-being of the beneficiary. We also added new paragraph (g) to reflect the payment adjustment for the insertion of NTIOLs.

• We made editorial changes to § 416.173 and § 416.178.

• We added new § 416.179, ''Payment and coinsurance reduction for devices replaced without cost or when full credit is received,'' as discussed in section IV.C. of this final rule.

VIII. Files Available to the Public Via the Internet

Addenda AA, BB, and DD1 to this final rule provide various data pertaining to the CY 2008 ASC list of covered procedures and the covered ancillary services that will be separately paid to ASCs beginning in CY 2008 when provided by an ASC as integral to a covered surgical procedure on the same day as the procedure. All relative payment weights and payment rates are illustrative only, demonstrating the payment rates that result from application of the revised ASC payment system methodology that we are finalizing in this final rule based on the most current data available. They exemplify the results of applying the revised ASC payment system methodology implemented in this final rule to the final or most recently updated CY 2007 OPPS information as updated by the currently estimated CY 2008 OPPS update factor and to the CY 2008 estimated transitional nonfacility practice expense amounts for the CY 2008 MPFS, with application of the projected CY 2008 MPFS update.

As further discussed in section VI. of this final rule, Addendum DD1 defines the payment indicators that are used in Addenda AA and BB of this final rule, while Addenda AA and BB provide payment information regarding covered surgical procedures and covered ancillary services under the revised ASC payment system.

These addenda, as well as the final rule preamble tables and other supporting data files, are included on the CMS Web site at: *http://www.cms.hhs.gov/ASCPayment/* in a format that can easily be downloaded and manipulated. Proposed and final ASC relative weights and payment rates for CY 2008 will be published in the proposed and final CY 2008 OPPS/ASC rules, respectively, and related data files will be included on the CMS Web site as noted above. The OPPS data files are available to the public on the CMS Web site at: *http://www.cms.hhs.gov/HospitalOutpatientPPS,* and the MPFS data files are located at: *http://www.cms.hhs.gov/PhysicianFeeSched.*

We are not including as addenda to this final rule reprints of the final FY 2007 IPPS wage indexes that were included in a notice published in the **Federal Register** on October 11, 2006 (71 FR 59886). Rather, we are providing a link on the CMS Web site at: *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN* to all of the final FY 2007 IPPS wage index related tables. The final CY 2008 ASC payment system will utilize the FY 2008 IPPS wage index related tables that will be proposed and finalized in the FY 2008 IPPS rulemaking cycle, and we will provide a link on the CMS Web site to those proposed and final wage index related tables in the CY 2008 OPPS/ASC proposed and final rules, respectively. For additional assistance, contact Gift Tee, (410) 786–0378.

IX. Collection of Information Requirements

This document does not impose any information collection and recordkeeping requirements. Consequently, it need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 35).

X. Regulatory Impact Analysis

A. Overall Impact

We have examined the impacts of this final 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 revised ASC payment system and the expanded ASC list of covered surgical procedures that we are implementing in CY 2008 will have no net effect on Medicare expenditures compared to the level of Medicare expenditures that would have occurred in CY 2008 in the absence of the revised payment system. A more detailed discussion of the effects of the changes to the ASC list of covered surgical procedures and the effects of the revisions to the ASC payment system in CY 2008 is provided in section X.B. below.

While we estimate that there will be no net change in Medicare expenditures in CY 2008 as a result of the revised ASC payment system, we estimate that the revised system will result in savings of $240 million over 5 years due to migration of new ASC covered surgical procedures from HOPDs and physicians' offices to ASCs over time. In addition, we note there will be a total increase in Medicare payments to ASCs for CY 2008 of approximately $270 million compared to Medicare expenditures that would have occurred in CY 2008 in the absence of the revised payment system. These additional payments to ASCs of approximately $270 million in CY 2008 will be fully offset by savings from reduced Medicare spending in HOPDs and physicians' offices on services that migrate from these settings to ASCs in CY 2008 (as discussed in detail in section V.C. of this final rule). Therefore, this final 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

The RFA requires agencies to determine whether a rule would have a significant economic impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $9 million to $31.5 million in any 1 year (65 FR 69432).

For purposes of the RFA, we have determined that approximately 73 percent of ASCs would be considered small businesses according to the Small Business Administration (SBA) size standards. Individuals and States are not included in the definition of a small entity. We anticipate that this final rule will have a significant impact on a substantial number of small entities.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA). The Secretary certifies that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 (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. This final 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 final 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. The changes related to payments to ASCs in CY 2008 will not affect payments to government hospitals.

B. Effects of Revisions to the ASC Payment System for CY 2008

In CY 2008, we are implementing a 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 greatly expanding the list of procedures that will be eligible for payment under the revised ASC payment system. Second, we are moving from a limited fee schedule based on nine disparate payment groups to a payment system incorporating relative payment weights for groups of procedures with similar clinical and resource characteristics, based on the APCs that are key elements of the OPPS.

Implementation by January 1, 2008 of a revised ASC payment system designed to result in budget neutrality is mandated by section 626 of Public Law 108–173. To set ASC payment rates for CY 2008 under the revised payment system, we are multiplying ASC relative payment weights for surgical procedures by an ASC conversion factor that we calculate to result in the same amount of aggregate Medicare expenditures for those services in CY 2008 as we estimate would have been made if the revised payment system were not implemented.

The effects of the expanded numbers and types of procedures for which an ASC payment may be made and other policy changes that affect the revised payment system, combined with significant changes in payment rates for covered surgical procedures, will vary across ASCs, depending on whether or not the ASC limits its services to those in a particular surgical specialty area, the volume of specific services provided by the ASC, the extent to which ASCs will offer different services, and the percentage of its patients that are Medicare beneficiaries.

In this July 2007 final rule for the revised ASC payment system, we have estimated the CY 2008 ASC payment rates, budget neutrality factor, and impacts using the CY 2007 OPPS relative payment weights with an estimated update factor for CY 2008, the CY 2007 MPFS PE RVUs trended forward to CY 2008, and CY 2005

utilization data projected forward to CY 2008. We emphasize that the impact estimates in this final rule are illustrative only. The CY 2008 ASC payment rates and budget neutrality factor will be proposed in the CY 2008 OPPS/ASC proposed rule based on the methodology for calculating budget neutrality established in this final rule and incorporating the proposed CY 2008 OPPS relative payment weights, the proposed CY 2008 MPFS PE RVUs, and CY 2006 utilization information projected forward to CY 2008. The final CY 2008 ASC payment rates and budget neutrality factor will be established in the CY 2008 OPPS/ASC final rule with comment period, in accordance with the methodology for calculating budget neutrality established in this final rule and based on the final CY 2008 OPPS payment weights, the final CY 2008 MPFS RVUs, and updated CY 2006 utilization data projected forward to CY 2008.

As discussed fully in section V.C. of this final rule, our final methodology for calculating the budget neutrality factor considers not only the effects of the new payment rates to be implemented under the revised payment system, but also the estimated net effect of migration of new ASC procedures across ambulatory care settings. The methodology for calculating the budget neutrality adjustment factor finalized in this rule assumes that over the first 2 years of the revised payment system, approximately 25 percent of the HOPD volume of new ASC procedures would migrate from the HOPD service setting to ASCs, and that over the 4-year transition period, approximately 15 percent of the physicians' office volume of new ASC procedures would migrate to ASCs.

We estimate that the revised ASC payment system established in this final rule will result in neither savings nor costs to the Medicare program in CY 2008. That is, because it is designed to be budget neutral, in CY 2008, the revised ASC payment system will neither increase nor decrease expenditures under Part B of Medicare. We further estimate that beneficiaries will save approximately $20 million under the revised ASC payment system in CY 2008, because ASC payment rates will, in most cases, be lower than OPPS payment rates for the same services and, because, except for screening flexible sigmoidoscopy and screening colonoscopy procedures, beneficiary coinsurance for ASC services is 20 percent rather than 20 to 40 percent as is the case under the OPPS. (The only possible instance in which an ASC coinsurance amount could exceed the OPPS copayment amount would be when the coinsurance amount for a procedure under the revised ASC payment system exceeds the hospital inpatient deductible. Section 1833(t)(8)(C)(i) of the Act provides that the copayment amount for a procedure paid under the OPPS cannot exceed the inpatient deductible established for the year in which the procedure is performed, but there is no such requirement related to the ASC coinsurance amount.) Beneficiary coinsurance for services migrating from physicians' offices to ASCs may decrease or increase under the revised ASC payment system, depending on the particular service and whether the Medicare payment to the physician for providing that service in his or her office is higher or lower than the sum of the Medicare payment to the ASC for providing the facility portion of that service and the Medicare payment to the physician for providing that service in a facility (nonoffice) setting. As noted previously, the net effect of the revised ASC payment system on beneficiary coinsurance, taking into account the migration of services from HOPDs and physicians' offices, is estimated to be $20 million in beneficiary savings in CY 2008.

1. Alternatives Considered

We are issuing this final rule to meet a statutory requirement to implement, no later than January 1, 2008, a revised payment system for ASCs. We are implementing the revised ASC payment system through rulemaking in the **Federal Register**. Through the August 2006 proposed rule, we have afforded interested parties an opportunity to comment on revisions we proposed to make to the policies and rules for identifying surgical procedures that would be excluded from payment in ASCs, to the ASC ratesetting methodology and payment policies, and to the regulations for the revised ASC payment system.

Throughout the preamble of this final rule, we discuss the various options we considered as we developed policies to redesign the ASC payment system in broad terms, and specific policies, such as those affecting payment for covered ancillary services integral to covered surgical procedures, the definition of a covered surgical procedure, criteria for identifying procedures that are not safely or appropriately performed in an ASC, and the payment methodology for device-intensive procedures, among others.

Although we proposed to phase in the new ASC payment rates under the revised payment system over a 2-year period, we are finalizing a policy to phase in the ASC payment rates under the revised payment system over a 4-year period. As we discuss in section X.B.3. of this final rule, we believe that allowing a longer transition period 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 decrease significantly under the revised payment system. We believe the 4-year transition will give ASCs time to reconfigure their mix of services and make other needed adjustments so they can focus on achieving more efficient delivery of a broader range of surgical procedures.

2. Limitations of Our Analysis

Presented here are the projected effects of the policy and statutory changes that will be effective for CY 2008 on aggregate ASC utilization and Medicare payments. One limitation of this analysis is that we could only infer the effects of the revised payment system on different types of ASCs, for example, single or multispecialty, high or low volume, and urban or nonurban ASCs, based on an overall comparison of procedure volumes and facility payments between the current and the revised payment system. At this time, we do not have a provider-level dataset of CY 2005 ASC utilization that accurately identifies unique ASCs and their geographic information that would allow us to compare estimated payments and geographic adjustment among classes of ASCs based on a provider-level analysis.

A second limitation is our lack of information on ASC resource use. ASCs are not required to file Medicare cost reports and, therefore, we do not have cost information to evaluate whether or not the payments for ASC services coincide with the resources required by ASCs to provide those services.

A third limitation is our inability to predict changes in service mix between CY 2005 and CY 2008. The aggregated impact tables below are based upon a methodology that assumes no changes in service-mix with respect to the CY 2005 ASC data used for this final rule. We believe that the net effect on Medicare expenditures of changes in service-mix for current ASC covered surgical procedures will be negligible, in the aggregate. Such changes may have differential effects across surgical specialty procedure groups as ASCs adjust to the revised payment system. However, we are unable to accurately project such changes at a disaggregated level. Clearly, individual ASCs will experience changes in payment that

differ from the aggregated estimated changes presented in the tables below.

Because we do not have experience with ASC payment under the revised payment system, we have relied on comments and information from stakeholders in response to our August 2006 proposed rule for the revised ASC payment system to mitigate the limitations in the data available to us for analysis of the impact of the changes on specific procedures, on classes of specialty ASCs, and on beneficiaries.

3. Estimated Effect of This Final 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, gastrointestinal procedures, or orthopedic surgery. The combined effect on an individual ASC of the CY 2008 revised payment system and the expanded ASC list of covered surgical procedures will depend on a number of factors, including, but not limited to, the mix of services the ASC provides, the volume of specific services provided by the ASC, the percentage of its patients who are Medicare beneficiaries, and the extent to which an ASC will choose to provide different services under the revised payment system. The following discussion presents two tables that provide estimates of the impact of the revised ASC payment system on Medicare payments to ASCs for current ASC services, assuming the same mix of services as offered by ASCs in our CY 2005 claims data. The first table depicts aggregate percent change in payment by surgical specialty group and the other compares payment for procedures estimated to receive the most payment in CY 2008 under the current payment system.

In section IV.J. of this final rule, we finalize our policy of a transition of 4 years for the revised payment rates, rather than the proposed 2-year transition, where payments will generally be made using a blend of the rates based on the CY 2007 ASC payment rate and the revised ASC payment rate. In comparing estimated payment rates for CY 2008 under the existing system with the estimated payment rates for CY 2008 under the revised system, we noted the negative effect the estimated proposed payment rates would have on Medicare payments to ASCs for certain surgical procedures that currently are performed frequently in ASCs. We were 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 revised system and wanted to encourage ASCs to continue to provide access to the high volume procedures that are currently performed there because, in all likelihood, the ASC has become an extremely efficient setting for those procedures, such as cataract extractions and colonoscopies. Moreover, we believe that a positive outcome of the revised ASC payment system could be to expand beneficiary and physician choice in selection of an appropriate site for ambulatory surgical services, as a consequence of the expansion of surgical procedures for which Medicare will make an ASC payment and the revised rates that will pay more appropriately for those services. We believe a 4-year transition will give ASCs additional time to reconfigure their mix of surgical services and make other needed adjustments so that they can focus on achieving more efficient delivery of a broader range of surgical procedures.

In CY 2008, we will pay ASCs using a 75/25 blend, in which payment will be calculated by adding 75 percent of the CY 2007 ASC rate for a surgical procedure on the CY 2007 ASC list of covered surgical procedures and 25 percent of the revised CY 2008 ASC rate for the same procedure. For CYs 2009 and 2010, the blend will be transitioned first to 50/50 and then to a 25/75 blend of the CY 2007 ASC rate and the revised ASC payment rate. Beginning in CY 2011, payments will be made to ASCs for covered surgical procedures on the CY 2007 ASC list at the fully implemented revised ASC payment rates. Procedures that were not included on the ASC list of covered surgical procedures in CY 2007 will not be paid at the transitional rates for CYs 2008 through 2010 because they have no CY 2007 ASC payment rate. Those procedures will be paid at the fully implemented ASC rate, beginning in CY 2008.

Table 11 shows the impact of the revised payment system at the surgical specialty group level. We have aggregated the surgical HCPCS codes by specialty group and estimated the effect on aggregated payment for surgical specialty groups, considering separately the CY 2008 transitional rate and the fully implemented revised payment rate. The groups are sorted for display in descending order by estimated Medicare program payment to ASCs for CY 2008 in the absence of the revised ASC payment system. The following is an explanation of the information presented in Table 11:

- Column 1—*Surgical Specialty Group* indicates the surgical specialties into which ASC procedures are grouped. We used the CPT code range definitions and added the related Level II HCPCS codes and Category III CPT codes, as appropriate, to account for all surgical procedures to which the Medicare program payments are attributed.
- Column 2—*Estimated CY 2008 ASC Payments* in the absence of the revised ASC payment system were calculated by multiplying the CY 2007 ASC payment rate by CY 2008 ASC utilization (which is based on CY 2005 ASC utilization multiplied by a factor of 1.305 to take into account expected volume growth with volume adjustment, as appropriate, for the multiple procedure discount). The resulting amount was then multiplied by 0.8 to estimate the Medicare program's share of the total payments to the ASC. The payment amounts are expressed in millions of dollars.
- Column 3—*Estimated CY 2008 Percent Change with Transition (75/25 Blend)* is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty group that is attributable to changes in the ASC payment rates for CY 2008 under the 75/25 blend of the CY 2007 ASC payment rate and the revised ASC payment rate.
- Column 4—*Estimated CY 2008 Percent Change without Transition (Fully Implemented)* is the aggregate percentage increase or decrease in Medicare program payment to ASCs for each surgical specialty group that is attributable to changes in the ASC payment rates for CY 2008 if there were no transition period to the revised payment rates. The percentages appearing in column 4 are presented as a comparison for the transition policy in column 3 and do not depict the impact of the fully implemented proposal in CY 2011.

Table 11 reflects the changes for ASCs at the surgical specialty level and shows that for all but gastrointestinal procedures, if an ASC offers the same mix of services in CY 2008 that is reflected in our national CY 2005 claims data, Medicare payments to the ASC for services in that surgical specialty area would be estimated to increase under the revised payment system. If the revised payment system were fully implemented in CY 2008, we would expect all but gastrointestinal procedures and nervous system procedures to receive greater Medicare payment. In addition to the impacts on

Medicare payments for current ASC procedures shown in Table 11, it is important to note that overall CY 2008 payments to ASCs are estimated to increase by about $270 million as a result of the revised payment system. This increased spending in ASCs is projected to be fully offset by savings from reduced spending in HOPDs and physicians' offices due to service migration.

TABLE 11.—ESTIMATED CY 2008 IMPACT OF THE REVISED ASC PAYMENT SYSTEM ON ESTIMATED AGGREGATE CY 2008 MEDICARE PROGRAM PAYMENTS UNDER THE 75/25 TRANSITION BLEND AND WITHOUT A TRANSITION, BY SURGICAL SPECIALTY GROUP

Surgical specialty group	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2008 percent change with transition (75/25 blend)	Estimated CY 2008 percent change without transition (fully implemented)
(1)	(2)	(3)	(4)
Eye and ocular adnexa	$1,365	1	5
Digestive system	721	−4	−15
Nervous system	274	2	−5
Musculoskeletal system	167	24	97
Integumentary system	85	4	15
Genitourinary system	76	10	38
Respiratory system	23	16	65
Cardiovascular system	8	25	95
Auditory system	4	30	85
Hemic and lymphatic systems	2	28	110
Other systems	0.1	19	75

Table 12 below shows the estimated impact of the revised payment system on aggregate ASC payments for selected procedures during the first year of implementation (CY 2008) with and without the transitional blended rate. The table displays 30 of the procedures receiving the highest estimated CY 2008 ASC payments under the existing Medicare payment system. The HCPCS codes are sorted in descending order by estimated CY 2008 ASC program payments in the absence of the revised ASC payment system.

- Column 1—*HCPCS code.*
- Column 2—*Short Descriptor* of the HCPCS code.
- Column 3—*Estimated CY 2008 ASC Payments* in the absence of the revised payment system were calculated by multiplying the CY 2007 ASC payment rate by CY 2008 ASC utilization (which is based on CY 2005 ASC utilization multiplied by a factor of 1.305 to take into account expected volume growth with volume adjustment, as appropriate, for the multiple procedure discount). The resulting amount was then multiplied by 0.8 to estimate the Medicare program's share of the total payments to the ASC. The payment amounts are expressed in millions of dollars.
- Column 4—*CY 2008 Percent Change with Transition (75/25 Blend)* reflects the percent differences between the estimated ASC payment rates for CY 2008 under the current system and the estimated payment rates for CY 2008 under the revised system, incorporating a 75/25 blend of the estimated ASC payment using the CY 2007 ASC payment rate and the revised ASC payment rate.
- Column 5—*CY 2008 Percent Change without Transition (Fully Implemented)* reflects the percent differences between the estimated ASC payment rates for CY 2008 under the current system and the estimated payment rates for CY 2008 under the revised payment system if there were no transition period to the revised payment rates. The percentages appearing in column 5 are presented as a comparison for the transition policy in column 4 and do not depict the impact of the fully implemented proposal in CY 2011.

TABLE 12.—ESTIMATED CY 2008 IMPACT OF REVISED ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR PROCEDURES WITH THE HIGHEST ESTIMATED CY 2008 PAYMENTS UNDER THE CURRENT SYSTEM

HCPCS code	Short descriptor	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2008 percent change (75/25 blend)	Estimated CY 2008 percent changes without transition (fully implemented)
(1)	(2)	(3)	(4)	(5)
66984	Cataract surg w/iol, 1 stage	$1,112	1	3
45378	Diagnostic colonoscopy	153	−4	−16
43239	Upper GI endoscopy, biopsy	148	−5	−21
45380	Colonoscopy and biopsy	114	−4	−16
66821	After cataract laser surgery	102	−8	−31
45385	Lesion removal colonoscopy	96	−4	−16
62311	Inject spine l/s (cd)	81	−5	−19
45384	Lesion remove colonoscopy	44	−4	−16

TABLE 12.—ESTIMATED CY 2008 IMPACT OF REVISED ASC PAYMENT SYSTEM ON AGGREGATE PAYMENTS FOR PROCEDURES WITH THE HIGHEST ESTIMATED CY 2008 PAYMENTS UNDER THE CURRENT SYSTEM—Continued

HCPCS code	Short descriptor	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2008 percent change (75/25 blend)	Estimated CY 2008 percent changes without transition (fully implemented)
(1)	(2)	(3)	(4)	(5)
64483	Inj foramen epidural l/s	44	−5	−19
G0121	Colon ca scrn not hi rsk ind	37	−6	−25
15823	Revision of upper eyelid	35	−4	−17
66982	Cataract surgery, complex	33	1	3
64476	Inj paravertebral l/s add-on	29	−7	−27
G0105	Colorectal scrn; hi risk ind	27	−6	−25
43235	Uppr gi endoscopy, diagnosis	25	2	6
52000	Cystoscopy	24	−4	−17
64475	Inj paravertebral l/s	24	−5	−19
67904	Repair eyelid defect	22	4	16
64721	Carpal tunnel surgery	17	18	70
29881	Knee arthroscopy/surgery	16	23	93
43248	Uppr gi endoscopy/guide wire	15	−5	−21
62310	Inject spine c/t	14	−5	−19
29880	Knee arthroscopy/surgery	11	23	93
64484	Inj foramen epidural add-on	11	−5	−19
28285	Repair of hammertoe	10	18	70
67038	Strip retinal membrane	10	31	122
29848	Wrist endoscopy/surgery	9	−2	−9
64623	Destr paravertebral n add-on	9	−5	−19
45383	Lesion removal colonoscopy	9	−4	−16
26055	Incise finger tendon sheath	9	14	54

Over time, we believe that the current ASC payment system has served as an incentive to ASCs to focus on providing procedures for which they determine Medicare payments are adequate to support the ASC's continued operation. We would expect that, under the existing payment system, the ASC payment rates for many of the most frequently performed procedures in ASCs are similar to the OPPS payment rates for the same procedures. Conversely, we would expect that procedures with existing ASC payment rates that are substantially lower than the OPPS rates would be performed less often in ASCs. We believe the revised ASC payment system represents a major stride towards encouraging greater efficiency in ASCs and promoting a significant increase in the breadth of surgical procedures performed in ASCs, because it more appropriately distributes payments across the entire spectrum of covered surgical procedures, based on a coherent system of relative payment weights that are related to the clinical and facility resource characteristics of those procedures.

Table 12 identifies a number of ASC procedures receiving the highest estimated CY 2008 payments under the current system and shows that most of them will experience payment decreases in CY 2008 under the revised ASC payment system. This contrasts with the estimated aggregate payment increases at the surgical specialty group level displayed in Table 11. In fact, Table 11 shows only one surgical specialty group of procedures for which the payments are expected to see a small decrease in the first year under the revised ASC payment system, and only two groups for which a decrease would be expected if there were no transition period to the revised payment rates. The increased payments at the full group level are due to the moderating effect of the payment increases for the less frequently performed procedures within the surgical specialty group. The exception to this is the surgical specialty group of eye and ocular adnexa where the aggregate increase in CY 2008 is driven by a small increase in payment for the highest volume procedure (CPT code 66984, Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedures), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)).

As a result of the redistribution of payments across the expanded breadth of surgical procedures for which Medicare will provide an ASC payment, we believe that ASCs may change the mix of services they provide over the next several years. The revised ASC payment system should encourage ASCs to expand their service mix beyond the handful of the highest paying procedures which comprise the majority of ASC utilization under the existing ASC payment system. For example, although cystoscopy (CPT code 52000), the highest volume ASC genitourinary procedure, is expected to experience a 4 percent payment rate decrease in CY 2008, overall payment to ASCs for the group of genitourinary procedures currently performed in ASCs is expected to increase by 10 percent. Although a urology specialty ASC may currently perform far more cystoscopy procedures than any other genitourinary procedure, we believe that under the revised ASC payment system, the ASC has the opportunity to adapt to the payment decrease for its most frequently performed procedures by offering an increased breadth of procedures, still within the clinical specialty area, and receive payments that are adequate to support continued operations. Similarly, payments for all of the highest volume pain management injection procedures are expected to decrease in CY 2008, although payments for nervous system procedures overall

are expected to increase. However, if there were no transition for CY 2008, payments would also decrease slightly for the nervous system surgical specialty group.

For those procedures that will be paid a significantly lower amount under the revised payment system than they are currently paid, we believe that their current payment rates, which are closer to the OPPS payment rates than other ASC procedures, are likely to be generous relative to ASC costs, so ASCs would in all likelihood continue performing those procedures under the revised payment system. We also note that the majority of the most frequently performed ASC procedures specifically studied by the GAO, as described in the section II.B. of this final rule for the revised ASC payment system, appear in Table 12 with estimated payment decreases under the revised ASC payment system. The GAO concluded that, for these procedures, the OPPS APC groups accurately reflect the relative costs of procedures performed at ASCs and that ASCs have substantially lower costs.

Generally, the payment changes for individual surgical procedures are relatively small in the first year under the transition to the revised payment system. As displayed in Table 12, a 1 percent increase in payment for the most common cataract surgery, CPT code 66984, is expected and mirrors the effect of the revised payment system on payment for the eye and ocular adnexa surgical specialty group (Table 11), even though payment for another relatively high volume eye procedure, CPT code 66821 (Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (e.g., YAG laser) (one or more stages)), is expected to decrease by 8 percent.

For some procedures the estimated payment amounts in CY 2008 under the revised ASC payment system are much higher than the CY 2007 rates currently paid to ASCs. For example, payment for CPT code 67038 (Vitrectomy, mechanical, pars plana approach; with epiretinal membrane stripping) increases by 31 percent compared to estimated CY 2008 payments under the current system. Similarly, the estimated CY 2008 ASC payment for CPT code 29880 (Arthroscopy, knee, surgical; with meniscetomy (medial and lateral, including any meniscal shaving)) increases by 23 percent. For these two procedures and the other procedures with estimated payment increases greater than 10 percent, the increases are due to the comparatively higher OPPS rates which, when adjusted by the ASC budget neutrality factor and blended with the CY 2007 ASC payment amounts, generate CY 2008 ASC payment rates that are substantially above the current CY 2007 ASC payment rates.

We estimate that payments for most of the highest volume colonoscopy and upper gastrointestinal endoscopy procedures will decrease under the revised payment system. In fact, payment decreases also are expected for the gastrointestinal surgical specialty group overall. We believe that decreased payments for so many of the gastrointestinal procedures are because current ASC payment rates are close to the OPPS rates. Procedures with current payment rates that are nearly as high as their OPPS rates are affected more negatively under the revised payment system than procedures for which ASC rates have historically been much lower than the comparable OPPS rates. The payment decreases expected in the first year under the revised ASC payment system for some of the high volume gastrointestinal procedures are not large (all less than 7 percent). We believe that ASCs can generally continue to cover their costs for these procedures, and that ASCs specializing in providing those services will be able to adapt their business practices and case-mix to manage declines for individual procedures.

In CY 2008, we also are adding hundreds of surgical procedures to the already extensive list of procedures for which Medicare allows payment to ASCs, creating new opportunities for ASCs to expand their range of covered surgical procedures. For the first time, ASCs will be paid separately for covered ancillary services that are integral to covered surgical procedures, including certain radiology procedures, costly drugs and biologicals, devices with pass-through status under the OPPS, and brachytherapy sources. While separately paid radiology services will be paid based on their ASC relative payment weight calculated according to the standard ratesetting methodology of the revised ASC payment system or to the MPFS nonfacility practice expense amount, whichever is lower, the other items newly eligible for separate payment in ASCs will be paid comparably to their OPPS rates because we would not expect ASCs to experience efficiencies in providing them. Lastly, this final rule establishes a specific payment methodology for device-intensive procedures that provides the same packaged payment for the device as under the OPPS, while providing a reduced service payment that is subject to the 4-year transition if the device-intensive procedure is on the CY 2007 ASC list of covered surgical procedures. This final methodology should allow ASCs to continue to expand their provision of device-intensive services and to begin performing new device-intensive ASC procedures.

4. Estimated Effects of This Final Rule on Beneficiaries

We estimate that the changes for CY 2008 will be positive for beneficiaries in at least two respects. Except for screening colonoscopy and flexible sigmoidoscopy procedures, the ASC coinsurance rate for all procedures is 20 percent. This contrasts with procedures performed in HOPDs where the beneficiary is responsible for copayments that range from 20 percent to 40 percent. In addition, ASC payment rates under the revised payment system are lower than payment rates for the same procedures under the OPPS, so the beneficiary coinsurance amount under the ASC payment system almost always will be less than the OPPS copayment amount for the same services. (The only exceptions will be when the ASC coinsurance amount exceeds the inpatient deductible. The statute requires that copayment amounts under the OPPS not exceed the inpatient deductible.) Beneficiary coinsurance for services migrating from physicians' offices to ASCs may decrease or increase under the revised ASC payment system, depending on the particular service and the relative payment amounts for that service in the physician's office compared with the ASC. As noted previously, the net effect of the revised ASC payment system on beneficiary coinsurance, taking into account the migration of services from HOPDs and physicians' offices, is estimated to be $20 million in beneficiary savings in CY 2008.

In addition to the lower out-of-pocket expenses, we believe that beneficiaries also will have access to more services in ASCs as a result of the addition of 793 surgical procedures to the ASC list of covered surgical services eligible for Medicare payment. We expect that ASCs will provide a broader range of surgical services under the revised payment system and that beneficiaries will benefit from having access to a greater variety of surgical procedures in ASCs.

5. Conclusion

The changes to the ASC payment system for CY 2008 will affect each of the more than 4,600 ASCs currently approved for participation in the Medicare program. The effect on an

individual ASC will depend on the ASC's mix of patients, the proportion of the ASC's patients that are Medicare beneficiaries, the degree to which the payments for the procedures offered by the ASC are changed under the revised payment system, and the degree to which the ASC chooses to provide a different set of procedures. The revised ASC payment system is designed to result in the same aggregate amount of Medicare expenditures in CY 2008 that would be made in the absence of the revised ASC payment system. As mentioned previously, we estimate that the revised ASC payment system and the expanded ASC list of covered surgical procedures that we are implementing in CY 2008 will have no net effect on Medicare expenditures compared to the level of Medicare expenditures that would have occurred in CY 2008 in the absence of the revised payment system. However, there will be a total increase in Medicare payments to ASCs for CY 2008 of approximately $270 million as a result of the revised ASC payment system, which will be fully offset by savings from reduced Medicare spending in HOPDs and physicians' offices on services that migrate from these settings to ASCs (as discussed in detail in section V.C. of this final rule). Furthermore, we estimate that the revised ASC payment system will result in Medicare savings of $240 million over 5 years due to migration of new ASC services from HOPDs and physicians' offices to ASCs over time. We anticipate that this final rule will have a significant economic impact on a substantial number of small entities.

6. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehousegov/omb/circulars/a004/a-4.pdf*), in Table 13 below, we have prepared an accounting statement showing the classification of the expenditures associated with the implementation of the CY 2008 revised ASC payment system, based on the provisions of this final rule. As explained above, we estimate that Medicare payments to ASCs in CY 2008 will be about $270 million higher than they would otherwise be in the absence of the revised ASC payment system. This $270 million in additional payments to ASCs in CY 2008 will be fully offset by savings from reduced spending in HOPDs and physicians' offices on services that migrate from these settings to ASCs. This table provides our best estimate of Medicare payments to providers and suppliers as a result of the CY 2008 revised ASC payment system, as presented in this final rule. All expenditures are classified as transfers.

TABLE 13.—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES FROM CY 2007 TO CY 2008 AS A RESULT OF THE CY 2008 REVISED ASC PAYMENT SYSTEM

Category	Transfers
Annualized Monetized Transfers.	$0 Million.
From Whom to Whom	Federal Government to Medicare Providers and Suppliers.
Annualized Monetized Transfer.	$0 Million.
From Whom to Whom	Premium Payments from Beneficiaries to Federal Government.
Total	$0 Million.

C. Executive Order 12866

In accordance with the provisions of Executive Order 12866, this final 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 416

Health facilities, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

■ For reasons stated in the preamble of this final rule, the Centers for Medicare & Medicaid Services is amending 42 CFR Chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

■ 1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 410.152 is amended by adding a new paragraph (i)(2) to read as follows:

§ 410.152 Amounts of payment.

* * * * *

(i) * * *

(2) For ASC services furnished on or after January 1, 2008, in connection with the covered surgical procedures specified in § 416.166 of this subchapter, except as provided in paragraphs (i)(2)(i) and (i)(2)(ii) of this section, Medicare Part B pays the lesser of 80 percent of the actual charge or 80 percent of the prospective payment amount, geographically adjusted, if applicable, as determined under Subpart F of Part 416 of this subchapter. Part B coinsurance is 20 percent of the actual charge or 20 percent of the prospective payment amount, geographically adjusted, if applicable.

(i) If the limitation described in § 416.167(b)(3) of this subchapter applies, Medicare pays 80 percent of the amount determined under Subpart B of Part 414 of this subchapter and Part B coinsurance is 20 percent of the applicable payment amount.

(ii) Medicare Part B pays 75 percent of the applicable payment amount for screening flexible sigmoidoscopies and screening colonoscopies, and Part B coinsurance is 25 percent of the applicable payment amount.

* * * * *

PART 416—AMBULATORY SURGICAL SERVICES

■ 3. The authority citation for part 416 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 4. Section 416.2 is amended by—
■ a. Revising the definition of ''ASC services.''
■ b. Adding a definition of ''Covered ancillary services'' in alphabetical order.
■ c. Revising the definition of ''Covered surgical procedures.''
■ d. Revising the definition of ''Facility services.''

The revisions and addition read as follows:

§ 416.2 Definitions.

* * * * *

ASC services means, for the period before January 1, 2008, facility services that are furnished in an ASC, and beginning January 1, 2008, means the combined facility services and covered ancillary services that are furnished in an ASC in connection with covered surgical procedures.

Covered ancillary services means items and services that are integral to a covered surgical procedure performed in an ASC as provided in § 416.164(b), for which payment may be made under § 416.171 in addition to the payment for the facility services.

Covered surgical procedures means those surgical procedures furnished before January 1, 2008, that meet the criteria specified in § 416.65 and those surgical procedures furnished on or after January 1, 2008, that meet the criteria specified in § 416.166.

Facility services means for the period before January 1, 2008, services that are furnished in connection with covered surgical procedures performed in an ASC, and beginning January 1, 2008, means services that are furnished in connection with covered surgical procedures performed in an ASC as provided in § 416.164(a) for which payment is included in the ASC payment established under § 416.171 for the covered surgical procedure.

■ 5. A new Subpart F is added to read as follows:

Subpart F—Coverage, Scope of ASC Services, and Prospective Payment System for ASC Services Furnished on or After January 1, 2008

Sec.

Subpart F—Coverage, Scope of ASC Services, and Prospective Payment System for ASC Services Furnished on or After January 1, 2008

§ 416.160 Basis and scope.

(a) *Statutory basis.* (1) Section 1833(i)(2)(D) of the Act requires the Secretary to implement a revised payment system for payment of surgical services furnished in ASCs. The statute requires that, in the year such system is implemented, the system shall be designed to result in the same amount of aggregate expenditures for such services as would be made if there was no requirement for a revised payment system. The revised payment system shall be implemented no earlier than January 1, 2006, and no later than January 1, 2008. 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.

(2) 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.

(3) 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.

(4) Section 1834(d) of the Act specifies that, when screening colonoscopies or screening flexible sigmoidoscopies are performed in an ASC or hospital outpatient department, payment shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area. Section 1834(d) of the Act further specifies that the coinsurance for screening flexible sigmoidoscopy and screening colonoscopy procedures is 25 percent of the payment amount. Section 1834(d) of the Act also specifies that, in the case of screening flexible sigmoidoscopy and screening colonoscopy services, their payment amounts must not exceed the payment rates established for the related diagnostic services. Section 1833(b)(8) of the Act specifies that the Part B deductible shall not apply with respect to colorectal screening tests as described in section 1861(pp)(1) of the Act, which include screening colonoscopies and screening flexible sigmoidoscopies.

(b) *Scope.* This subpart sets forth—

(1) The scope of ASC services and the criteria for determining the covered surgical procedures for which Medicare provides payment for the associated facility services and covered ancillary services;

(2) The basis of payment for facility services and for covered ancillary services furnished in an ASC in connection with a covered surgical procedure;

(3) The methodologies by which Medicare determines payment amounts for ASC services.

§ 416.161 Applicability of this subpart.

The provisions of this subpart apply to ASC services furnished on or after January 1, 2008.

§ 416.163 General rules.

(a) Payment is made under this subpart for ASC services specified in §§ 416.164(a) and (b) 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) Payment for physicians' services and payment for anesthetists' services are made in accordance with Part 414 of this subchapter.

(c) Payment for items and services other than physicians' and anesthetists' services, as specified in § 416.164(c), is made in accordance with § 410.152 of this subchapter.

§ 416.164 Scope of ASC services.

(a) *Included facility services.* ASC services for which payment is packaged into the ASC payment for a covered surgical procedure under § 416.166 include, but are not limited to—

(1) Nursing, technician, and related services;

(2) Use of the facility where the surgical procedures are performed;

(3) Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver;

(4) Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS);

(5) Medical and surgical supplies not on pass-through status under Subpart G of Part 419 of this subchapter;

(6) Equipment;

(7) Surgical dressings;

(8) Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under Subpart G of Part 419 of this subchapter;

(9) Implanted DME and related accessories and supplies not on pass-through status under Subpart G of Part 419 of this subchapter;

(10) Splints and casts and related devices;

(11) Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;

(12) Administrative, recordkeeping and housekeeping items and services;

(13) Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

(14) Supervision of the services of an anesthetist by the operating surgeon.

(b) *Covered ancillary services.* Ancillary items and services that are integral to a covered surgical procedure, as defined in § 416.166, and for which separate payment is allowed include:

(1) Brachytherapy sources;

(2) Certain implantable items that have pass-through status under the OPPS;

(3) Certain items and services that CMS designates as contractor-priced,

including, but not limited to, the procurement of corneal tissue;

(4) Certain drugs and biologicals for which separate payment is allowed under the OPPS;

(5) Certain radiology services for which separate payment is allowed under the OPPS.

(c) *Excluded services.* ASC services do not include items and services outside the scope of ASC services for which payment may be made under Part 414 of this subchapter in accordance with § 410.152, including, but not limited to—

(1) Physicians' services (including surgical procedures and all preoperative and postoperative services that are performed by a physician);

(2) Anesthetists' services;

(3) Radiology services (other than those integral to performance of a covered surgical procedure);

(4) Diagnostic procedures (other than those directly related to performance of a covered surgical procedure);

(5) Ambulance services;

(6) Leg, arm, back, and neck braces other than those that serve the function of a cast or splint;

(7) Artificial limbs;

(8) Nonimplantable prosthetic devices and DME.

§ 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 and published in the **Federal Register** that are separately paid under the OPPS, that would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC, and for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.

(c) *General exclusions.* Notwithstanding paragraph (b) of this section, covered surgical procedures do not include those surgical 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) Commonly require systemic thrombolytic therapy;

(6) Are designated as requiring inpatient care under § 419.22(n) of this subchapter;

(7) Can only be reported using a CPT unlisted surgical procedure code; or

(8) Are otherwise excluded under § 411.15 of this subchapter.

§ 416.167 Basis of payment.

(a) *Unit of payment.* Under the ASC payment system, prospectively determined amounts are paid for ASC services furnished to Medicare beneficiaries in connection with covered surgical procedures. Covered surgical procedures and covered ancillary services are identified by codes established under the Healthcare Common Procedure Coding System (HCPCS). The unadjusted national payment rate is determined according to the methodology described in § 416.171. The manner in which the Medicare payment amount and the beneficiary coinsurance amount for each ASC service is 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 subchapter.

(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 relative payment weight is determined based on the APC relative payment weight for each covered surgical procedure and covered ancillary service that has an applicable APC relative payment weight described in § 419.31 of this subchapter.

(3) Notwithstanding paragraph (b)(2) of this section, the relative payment weights for services paid in accordance with § 416.171(d) are determined so that the national ASC payment rate does not exceed the unadjusted nonfacility practice expense amount paid under the Medicare physician fee schedule for such procedures under Subpart B of Part 414 of this subchapter.

§ 416.171 Determination of payment rates for ASC services.

(a) *Standard methodology.* The standard methodology for determining the national unadjusted payment rate for ASC services is to calculate the product of the applicable conversion factor and the relative payment weight established under § 416.167(b), unless otherwise indicated in this section.

(1) *Conversion factor for CY 2008.* CMS calculates a conversion factor so that payment for ASC services furnished in CY 2008 would result in the same aggregate amount of expenditures as would be made if the provisions in this Subpart F did not apply, as estimated by CMS.

(2) *Conversion factor for CY 2009 and subsequent calendar years.* The conversion factor for a calendar year is equal to the conversion factor calculated for the previous year, updated as follows:

(i) For CY 2009, the update is equal to zero percent.

(ii) For CY 2010 and subsequent calendar years, the update is 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.

(b) *Exception.* The national ASC payment rates for the following items and services are not determined in accordance with paragraph (a) of this section but are paid an amount derived from the payment rate for the equivalent item or service set under the payment system established in Part 419 of this subchapter as updated annually in the **Federal Register**. If a payment rate is not available, the following items and services are designated as contractor-priced:

(1) Covered ancillary services specified in § 416.164(b), with the exception of radiology services as provided in § 416.164(b)(5);

(2) Device-intensive procedures assigned to device-dependent APCs under the OPPS with device costs greater than 50 percent of the APC cost;

(3) Procedures using certain separately paid implantable devices that are approved for transitional pass-through payment in accordance with § 419.66 of this subchapter.

(c) *Transitional payment rates.* (1) ASC payment rates for CY 2008 are a transitional blend of 75 percent of the CY 2007 ASC payment rate for a covered surgical procedure on the CY 2007 ASC list of surgical procedures and 25 percent of the payment rate for the procedure calculated under the methodology described in paragraph (a) of this section.

(2) ASC payment rates for CY 2009 are a transitional blend of 50 percent of the CY 2007 ASC payment rate for a covered 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 (a) of this section.

(3) ASC payment rates for CY 2010 are a transitional blend of 25 percent of the CY 2007 ASC payment rate for a

covered surgical procedure on the CY 2007 ASC list of surgical procedures and 75 percent of the payment rate for the procedure calculated under the methodology described in paragraph (a) of this section.

(4) The national ASC payment rate for CY 2011 and subsequent calendar years for a covered surgical procedure designated in accordance with § 416.166 is the payment rates for the procedure calculated under the methodology described in paragraph (a) of this section.

(5) Covered ancillary services described in § 416.164(b) and surgical procedures identified as covered when performed in an ASC under § 416.166 for the first time beginning on or after January 1, 2008, are not subject to the transitional payment rates applicable in CYs 2008 through 2010 for ASC facility services.

(d) *Limitation on payment rates for office-based surgical procedures and covered ancillary radiology services.* Notwithstanding the provisions of paragraph (a) of this section, for any covered surgical procedure under § 416.166 that CMS determines is commonly performed in physicians' offices or for any covered ancillary radiology service, the national unadjusted ASC payment rates for these procedures and services will be the lesser of the amount determined under paragraph (a) of this section or the amount calculated at the nonfacility practice expense relative value units under § 414.22(b)(5)(i)(B) of this subchapter multiplied by the conversion factor described in § 414.20(a)(3) of this subchapter.

(e) *Budget neutrality.* (1) For CY 2008, CMS establishes the conversion factor to result in budget neutrality as estimated by CMS in accordance with paragraph (a)(1) of this section.

(2) For CY 2009 and subsequent calendar 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 subchapter are budget neutral as estimated by CMS.

§ 416.172 Adjustments to national payment rates.

(a) *General rule.* Contractors adjust the payment rates established for ASC services to determine Medicare program payment and beneficiary coinsurance amounts in accordance with paragraphs (b) through (g) of this section.

(b) *Lesser of actual charge or geographically adjusted payment rate.* Payments to ASCs equal 80 percent of the lesser of—

(1) The actual charge for the service; or

(2) The geographically adjusted payment rate determined under this subpart.

(c) *Geographic adjustment.*—(1) *General rule.* Except as provided in paragraph (c)(2) of this section, the 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 nonlabor percentages, and localities specified by the Secretary.

(2) *Exception.* The geographic adjustment is not applied to the payment rates set for drugs, biologicals, devices with OPPS transitional pass-through payment status, and brachytherapy sources.

(d) *Deductibles and coinsurance.* Part B deductible and coinsurance amounts apply as specified in §§ 410.152(a) and (i)(2) of this subchapter.

(e) *Payment reductions for multiple surgical procedures.*—(1) *General rule.* Except as provided in paragraph (e)(2) of this section, when more than one covered surgical procedure for which payment is made under the ASC payment system is performed during an operative session, the Medicare program payment amount and the beneficiary coinsurance amount are based on—

(i) 100 percent of the applicable ASC payment amount for the procedure with the highest national unadjusted ASC payment rate; and

(ii) 50 percent of the applicable ASC payment amount for all other covered surgical procedures.

(2) *Exception: Procedures not subject to multiple procedure discounting.* CMS 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 subchapter as may be consistent with the equitable and efficient administration of this part.

(f) *Interrupted procedures.* When a covered surgical procedure or covered ancillary service is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary coinsurance amount are based on one of the following—

(1) The full program and beneficiary coinsurance amounts if the procedure for which anesthesia is planned is discontinued after the induction of anesthesia or after the procedure is started;

(2) One-half of the full program and beneficiary coinsurance amounts if the procedure for which anesthesia is planned is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed but before the anesthesia is induced; or

(3) One-half of the full program and beneficiary coinsurance amounts if a covered surgical procedure or covered ancillary service for which anesthesia is not planned is discontinued after the patient is prepared and taken to the room where the service is to be provided.

(g) *Payment adjustment for new technology intraocular lenses (NTIOLs).* A payment adjustment will be made for insertion of an IOL approved as belonging to a class of NTIOLs as defined in Subpart G.

§ 416.173 Publication of revised payment methodologies and payment rates.

CMS publishes annually, through notice and comment rulemaking in the **Federal Register**, the payment methodologies and payment rates for ASC services and designates the covered surgical procedures and covered ancillary services for which CMS will make an ASC payment and other revisions as appropriate.

§ 416.178 Limitations on administrative and judicial review.

There is no administrative or judicial review under section 1869 of the Act, section 1878 of the Act, or otherwise of the following:

(a) The classification system;

(b) Relative weights;

(c) Payment amounts; and

(d) Geographic adjustment factors.

§ 416.179 Payment and coinsurance reduction for devices replaced without cost or when full credit is received.

(a) *General rule.* CMS reduces the amount of payment for a covered surgical procedure for which CMS determines that a significant portion of the payment is attributable to the cost of an implanted device not on pass-through status under Subpart G of Part 419 of this subchapter when one of the following situations occur:

(1) The device is replaced without cost to the ASC or the beneficiary; or

(2) The ASC receives full credit for the cost of a replaced device.

(b) *Amount of reduction to the ASC payment for the covered surgical procedure.* The amount of the reduction to the ASC payment made under paragraph (a) of this section is calculated in the same manner as the device payment reduction that would be applied to the ASC payment for the covered surgical procedure in order to remove predecessor device costs so that

the ASC payment amount for a device with pass-through status under § 419.66 of this subchapter represents the full cost of the device, and no packaged device payment is provided through the ASC payment for the covered surgical procedure.

(c) *Amount of beneficiary coinsurance.* The beneficiary coinsurance is calculated based on the ASC payment for the covered surgical procedure after application of the reduction under paragraph (b) of this section.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: April 24, 2007.

Leslie Norwalk,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: May 31, 2007.

Michael O. Leavitt,

Secretary.

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
0016T	Thermotx choroids vasc lesion	Y	R2		3.9333	$167.33	$167.33
0017T	Photocoagulat macular drusen	Y	R2		3.9333	$167.33	$167.33
0027T	Endoscopic epidural lysis	Y	G2		17.8499	$759.39	$759.39
0031T	Speculoscopy		N1				
0032T	Speculoscopy w/direct sample		N1				
0046T	Cath lavage, mammary duct(s)	Y	R2		15.1024	$642.50	$642.50
0047T	Cath lavage, mammary duct(s)	Y	R2		15.1024	$642.50	$642.50
0062T	Rep intradisc annulus;1 lev	Y	G2		25.1296	$1,069.09	$1,069.09
0063T	Rep intradisc annulus;>1lev	Y	G2		25.1296	$1,069.09	$1,069.09
0084T	Temp prostate urethral stent	Y	G2		2.1393	$91.01	$91.01
0099T*	Implant corneal ring	Y	R2		15.2259	$647.76	$647.76
0100T	Prosth retina receive&gen	Y	G2		37.4290	$1,592.34	$1,592.34
0101T	Extracorp shockwv tx,hi enrg	Y	G2		25.1296	$1,069.09	$1,069.09
0102T	Extracorp shockwv tx,anesth	Y	G2		25.1296	$1,069.09	$1,069.09
0123T	Scleral fistulization	Y	G2		22.9970	$978.36	$978.36
0124T*	Conjunctival drug placement	Y	R2		6.0673	$258.12	$258.12
0133T	Esophageal implant injexn	Y	G2		25.7552	$1,095.70	$1,095.70
0176T	Aqu canal dilat w/o retent	Y	A2	$1,339.00	37.8967	$1,612.24	$1,407.31
0177T	Aqu canal dilat w retent	Y	A2	$1,339.00	37.8967	$1,612.24	$1,407.31
10021	Fna w/o image	Y	P2		1.0995	$46.78	$46.78
10022	Fna w/image	Y	G2		2.0738	$88.23	$88.23
10040	Acne surgery	Y	P2		0.4760	$20.25	$20.25
10060	Drainage of skin abscess	Y	P3		1.0944	$46.56	$46.56
10061	Drainage of skin abscess	Y	P2		1.4392	$61.23	$61.23
10080	Drainage of pilonidal cyst	Y	P2		1.4392	$61.23	$61.23
10081	Drainage of pilonidal cyst	Y	P3		3.0339	$129.07	$129.07
10120	Remove foreign body	Y	P2		1.4392	$61.23	$61.23
10121	Remove foreign body	Y	A2	$446.00	15.1024	$642.50	$495.13
10140	Drainage of hematoma/fluid	Y	P3		1.6174	$68.81	$68.81
10160	Puncture drainage of lesion	Y	P2		1.0259	$43.64	$43.64
10180	Complex drainage, wound	Y	A2	$446.00	17.5086	$744.87	$520.72
11000	Debride infected skin	Y	P3		0.5312	$22.60	$22.60
11001	Debride infected skin add-on	Y	P3		0.1850	$7.87	$7.87
11010	Debride skin, fx	Y	A2	$251.52	4.0919	$174.08	$232.16
11011	Debride skin/muscle, fx	Y	A2	$251.52	4.0919	$174.08	$232.16
11012	Debride skin/muscle/bone, fx	Y	A2	$251.52	4.0919	$174.08	$232.16
11040	Debride skin, partial	Y	P3		0.4828	$20.54	$20.54
11041	Debride skin, full	Y	P3		0.5632	$23.96	$23.96
11042	Debride skin/tissue	Y	A2	$164.42	2.6749	$113.80	$151.77
11043	Debride tissue/muscle	Y	A2	$164.42	2.6749	$113.80	$151.77
11044	Debride tissue/muscle/bone	Y	A2	$423.10	6.8832	$292.83	$390.53
11055	Trim skin lesion	Y	P3		0.5552	$23.62	$23.62
11056	Trim skin lesions, 2 to 4	Y	P3		0.6116	$26.02	$26.02
11057	Trim skin lesions, over 4	Y	P3		0.7000	$29.78	$29.78
11100	Biopsy, skin lesion	Y	P2		1.0259	$43.64	$43.64
11101	Biopsy, skin add-on	Y	P3		0.2978	$12.67	$12.67
11200	Removal of skin tags	Y	P3		0.9174	$39.03	$39.03
11201	Remove skin tags add-on	Y	P3		0.1288	$5.48	$5.48
11300	Shave skin lesion	Y	P2		0.8432	$35.87	$35.87
11301	Shave skin lesion	Y	P2		0.8432	$35.87	$35.87
11302	Shave skin lesion	Y	P2		1.0918	$46.45	$46.45
11303	Shave skin lesion	Y	P3		1.4484	$61.62	$61.62
11305	Shave skin lesion	Y	P3		0.7726	$32.87	$32.87
11306	Shave skin lesion	Y	P3		1.0140	$43.14	$43.14
11307	Shave skin lesion	Y	P2		1.0918	$46.45	$46.45
11308	Shave skin lesion	Y	P2		1.0918	$46.45	$46.45
11310	Shave skin lesion	Y	P3		1.0058	$42.79	$42.79
11311	Shave skin lesion	Y	P2		1.0918	$46.45	$46.45
11312	Shave skin lesion	Y	P2		1.0918	$46.45	$46.45
11313	Shave skin lesion	Y	P3		1.6094	$68.47	$68.47
11400	Exc tr-ext b9+marg 0.5 <cm	Y	P3		1.5530	$66.07	$66.07
11401	Exc tr-ext b9+marg 0.6–1 cm	Y	P3		1.6980	$72.24	$72.24
11402	Exc tr-ext b9+marg 1.1–2 cm	Y	P3		1.8508	$78.74	$78.74

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
11403	Exc tr-ext b9+marg 2.1–3 cm	Y	P3		1.9876	$84.56	$84.56
11404	Exc tr-ext b9+marg 3.1–4 cm	Y	A2	$333.00	15.1024	$642.50	$410.38
11406	Exc tr-ext b9+marg > 4.0 cm	Y	A2	$446.00	15.1024	$642.50	$495.13
11420	Exc h-f-nk-sp b9+marg 0.5<	Y	P3		1.4484	$61.62	$61.62
11421	Exc h-f-nk-sp b9+marg 0.6–1	Y	P3		1.7220	$73.26	$73.26
11422	Exc h-f-nk-sp b9+marg 1.1–2	Y	P3		1.8750	$79.77	$79.77
11423	Exc h-f-nk-sp b9+marg 2.1–3	Y	P3		2.1085	$89.70	$89.70
11424	Exc h-f-nk-sp b9+marg 3.1–4	Y	A2	$446.00	15.1024	$642.50	$495.13
11426	Exc h-f-nk-sp b9+marg > 4 cm	Y	A2	$446.00	20.0656	$853.65	$547.91
11440	Exc face-mm b9+marg 0.5 < cm	Y	P3		1.6898	$71.89	$71.89
11441	Exc face-mm b9+marg 0.6–1 cm	Y	P3		1.8993	$80.80	$80.80
11442	Exc face-mm b9+marg 1.1–2 cm	Y	P3		2.0763	$88.33	$88.33
11443	Exc face-mm b9+marg 2.1-3 cm	Y	P3		2.3256	$98.94	$98.94
11444	Exc face-mm b9+marg 3.1–4 cm	Y	A2	$333.00	6.8083	$289.65	$322.16
11446	Exc face-mm b9+marg > 4 cm	Y	A2	$446.00	20.0656	$853.65	$547.91
11450	Removal, sweat gland lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
11451	Removal, sweat gland lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
11462	Removal, sweat gland lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
11463	Removal, sweat gland lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
11470	Removal, sweat gland lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
11471	Removal, sweat gland lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
11600	Exc tr-ext mlg+marg 0.5 < cm	Y	P3		2.1646	$92.09	$92.09
11601	Exc tr-ext mlg+marg 0.6–1 cm	Y	P3		2.4787	$105.45	$105.45
11602	Exc tr-ext mlg+marg 1.1-2 cm	Y	P3		2.6879	$114.35	$114.35
11603	Exc tr-ext mlg+marg 2.1–3 cm	Y	P3		2.8729	$122.22	$122.22
11604	Exc tr-ext mlg+marg 3.1–4 cm	Y	A2	$418.49	6.8083	$289.65	$386.28
11606	Exc tr-ext mlg+marg > 4 cm	Y	A2	$446.00	15.1024	$642.50	$495.13
11620	Exc h-f-nk-sp mlg+marg 0.5	Y	P3		2.1888	$93.12	$93.12
11621	Exc h-f-nk-sp mlg+marg 0.6–1	Y	P3		2.4947	$106.13	$106.13
11622	Exc h-f-nk-sp mlg+marg 1.1–2	Y	P3		2.7683	$117.77	$117.77
11623	Exc h-f-nk-sp mlg+marg 2.1–3	Y	P3		3.0017	$127.70	$127.70
11624	Exc h-f-nk-sp mlg+marg 3.1–4	Y	A2	$446.00	15.1024	$642.50	$495.13
11626	Exc h-f-nk-sp mlg+mar > 4 cm	Y	A2	$446.00	20.0656	$853.65	$547.91
11640	Exc face-mm malig+marg 0.5<	Y	P3		2.2934	$97.57	$97.57
11641	Exc face-mm malig+marg 0.6–1	Y	P3		2.6796	$114.00	$114.00
11642	Exc face-mm malig+marg 1.1–2	Y	P3		2.9937	$127.36	$127.36
11643	Exc face-mm malig+marg 2.1–3	Y	P3		3.2511	$138.31	$138.31
11644	Exc face-mm malig+marg 3.1–4	Y	A2	$446.00	15.1024	$642.50	$495.13
11646	Exc face-mm mlg+marg > 4 cm	Y	A2	$446.00	20.0656	$853.65	$547.91
11719	Trim nail(s)	Y	P3		0.2494	$10.61	$10.61
11720	Debride nail, 1–5	Y	P3		0.3218	$13.69	$13.69
11721	Debride nail, 6 or more	Y	P3		0.4024	$17.12	$17.12
11730	Removal of nail plate	Y	P3		0.9576	$40.74	$40.74
11732	Remove nail plate, add-on	Y	P3		0.4024	$17.12	$17.12
11740	Drain blood from under nail	Y	P3		0.5392	$22.94	$22.94
11750	Removal of nail bed	Y	P3		2.0763	$88.33	$88.33
11752	Remove nail bed/finger tip	Y	P3		2.8729	$122.22	$122.22
11755	Biopsy, nail unit	Y	P3		1.4566	$61.97	$61.97
11760	Repair of nail bed	Y	G2		1.4843	$63.15	$63.15
11762	Reconstruction of nail bed	Y	P2		1.4843	$63.15	$63.15
11765	Excision of nail fold, toe	Y	P2		1.6241	$69.09	$69.09
11770	Removal of pilonidal lesion	Y	A2	$510.00	20.0656	$853.65	$595.91
11771	Removal of pilonidal lesion	Y	A2	$510.00	20.0656	$853.65	$595.91
11772	Removal of pilonidal lesion	Y	A2	$510.00	20.0656	$853.65	$595.91
11900	Injection into skin lesions	Y	P3		0.6358	$27.05	$27.05
11901	Added skin lesions injection	Y	P3		0.6760	$28.76	$28.76
11920	Correct skin color defects	Y	P2		1.4843	$63.15	$63.15
11921	Correct skin color defects	Y	P2		1.4843	$63.15	$63.15
11922	Correct skin color defects	Y	P3		0.8368	$35.60	$35.60
11950	Therapy for contour defects	Y	P3		0.8048	$34.24	$34.24
11951	Therapy for contour defects	Y	P3		1.0784	$45.88	$45.88
11952	Therapy for contour defects	Y	P3		1.4484	$61.62	$61.62
11954	Therapy for contour defects	Y	P2		1.4843	$63.15	$63.15

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
11960	Insert tissue expander(s)	Y	A2	$446.00	21.4302	$911.71	$562.43
11970	Replace tissue expander	Y	A2	$510.00	41.0893	$1,748.06	$819.52
11971	Remove tissue expander(s)	Y	A2	$333.00	20.0656	$853.65	$463.16
11976	Removal of contraceptive cap	Y	P3		1.3760	$58.54	$58.54
11980	Implant hormone pellet(s)	N	P2		0.6102	$25.96	$25.96
11981	Insert drug implant device	N	P2		0.6102	$25.96	$25.96
11982	Remove drug implant device	N	P2		0.6102	$25.96	$25.96
11983	Remove/insert drug implant	N	P2		0.6102	$25.96	$25.96
12001	Repair superficial wound(s)	Y	P2		1.4843	$63.15	$63.15
12002	Repair superficial wound(s)	Y	P2		1.4843	$63.15	$63.15
12004	Repair superficial wound(s)	Y	P2		1.4843	$63.15	$63.15
12005	Repair superficial wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12006	Repair superficial wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12007	Repair superficial wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12011	Repair superficial wound(s)	Y	P2		1.4843	$63.15	$63.15
12013	Repair superficial wound(s)	Y	P2		1.4843	$63.15	$63.15
12014	Repair superficial wound(s)	Y	P2		1.4843	$63.15	$63.15
12015	Repair superficial wound(s)	Y	G2		1.4843	$63.15	$63.15
12016	Repair superficial wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12017	Repair superficial wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12018	Repair superficial wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12020	Closure of split wound	Y	A2	$91.24	1.4843	$63.15	$84.22
12021	Closure of split wound	Y	A2	$91.24	1.4843	$63.15	$84.22
12031	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12032	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12034	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12035	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12036	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12037	Layer closure of wound(s)	Y	A2	$323.28	5.2594	$223.75	$298.40
12041	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12042	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12044	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12045	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12046	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12047	Layer closure of wound(s)	Y	A2	$323.28	5.2594	$223.75	$298.40
12051	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12052	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12053	Layer closure of wound(s)	Y	P2		1.4843	$63.15	$63.15
12054	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12055	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12056	Layer closure of wound(s)	Y	A2	$91.24	1.4843	$63.15	$84.22
12057	Layer closure of wound(s)	Y	A2	$323.28	5.2594	$223.75	$298.40
13100	Repair of wound or lesion	Y	A2	$323.28	5.2594	$223.75	$298.40
13101	Repair of wound or lesion	Y	A2	$323.28	5.2594	$223.75	$298.40
13102	Repair wound/lesion add-on	Y	A2	$91.24	1.4843	$63.15	$84.22
13120	Repair of wound or lesion	Y	A2	$91.24	1.4843	$63.15	$84.22
13121	Repair of wound or lesion	Y	A2	$91.24	1.4843	$63.15	$84.22
13122	Repair wound/lesion add-on	Y	A2	$91.24	1.4843	$63.15	$84.22
13131	Repair of wound or lesion	Y	A2	$91.24	1.4843	$63.15	$84.22
13132	Repair of wound or lesion	Y	A2	$91.24	1.4843	$63.15	$84.22
13133	Repair wound/lesion add-on	Y	A2	$91.24	1.4843	$63.15	$84.22
13150	Repair of wound or lesion	Y	A2	$323.28	5.2594	$223.75	$298.40
13151	Repair of wound or lesion	Y	A2	$323.28	5.2594	$223.75	$298.40
13152	Repair of wound or lesion	Y	A2	$323.28	5.2594	$223.75	$298.40
13153	Repair wound/lesion add-on	Y	A2	$91.24	1.4843	$63.15	$84.22
13160	Late closure of wound	Y	A2	$446.00	21.4302	$911.71	$562.43
14000	Skin tissue rearrangement	Y	A2	$446.00	14.0346	$597.07	$483.77
14001	Skin tissue rearrangement	Y	A2	$510.00	21.4302	$911.71	$610.43
14020	Skin tissue rearrangement	Y	A2	$510.00	14.0346	$597.07	$531.77
14021	Skin tissue rearrangement	Y	A2	$510.00	14.0346	$597.07	$531.77
14040	Skin tissue rearrangement	Y	A2	$446.00	14.0346	$597.07	$483.77
14041	Skin tissue rearrangement	Y	A2	$510.00	14.0346	$597.07	$531.77
14060	Skin tissue rearrangement	Y	A2	$510.00	14.0346	$597.07	$531.77

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
14061	Skin tissue rearrangement	Y	A2	$510.00	14.0346	$597.07	$531.77
14300	Skin tissue rearrangement	Y	A2	$630.00	21.4302	$911.71	$700.43
14350	Skin tissue rearrangement	Y	A2	$510.00	21.4302	$911.71	$610.43
15002	Wnd prep, ch/inf, trk/arm/lg	Y	A2	$323.28	5.2594	$223.75	$298.40
15003	Wnd prep, ch/inf addl 100 cm	Y	A2	$323.28	5.2594	$223.75	$298.40
15004	Wnd prep ch/inf, f/n/hf/g	Y	A2	$323.28	5.2594	$223.75	$298.40
15005	Wnd prep, f/n/hf/g, addl cm	Y	A2	$323.28	5.2594	$223.75	$298.40
15040	Harvest cultured skin graft	Y	A2	$91.24	1.4843	$63.15	$84.22
15050	Skin pinch graft	Y	A2	$323.28	5.2594	$223.75	$298.40
15100	Skin splt grft, trnk/arm/leg	Y	A2	$446.00	21.4302	$911.71	$562.43
15101	Skin splt grft t/a/l, add-on	Y	A2	$510.00	21.4302	$911.71	$610.43
15110	Epidrm autogrft trnk/arm/leg	Y	A2	$446.00	21.4302	$911.71	$562.43
15111	Epidrm autogrft t/a/l add-on	Y	A2	$333.00	21.4302	$911.71	$477.68
15115	Epidrm a-grft face/nck/hf/g	Y	A2	$446.00	21.4302	$911.71	$562.43
15116	Epidrm a-grft f/n/hf/g addl	Y	A2	$333.00	21.4302	$911.71	$477.68
15120	Skn splt a-grft fac/nck/hf/g	Y	A2	$446.00	21.4302	$911.71	$562.43
15121	Skn splt a-grft f/n/hf/g add	Y	A2	$510.00	21.4302	$911.71	$610.43
15130	Derm autograft, trnk/arm/leg	Y	A2	$446.00	21.4302	$911.71	$562.43
15131	Derm autograft t/a/l add-on	Y	A2	$333.00	21.4302	$911.71	$477.68
15135	Derm autograft face/nck/hf/g	Y	A2	$446.00	21.4302	$911.71	$562.43
15136	Derm autograft, f/n/hf/g add	Y	A2	$333.00	21.4302	$911.71	$477.68
15150	Cult epiderm grft t/arm/leg	Y	A2	$446.00	21.4302	$911.71	$562.43
15151	Cult epiderm grft t/a/l addl	Y	A2	$333.00	21.4302	$911.71	$477.68
15152	Cult epiderm graft t/a/l +%	Y	A2	$333.00	21.4302	$911.71	$477.68
15155	Cult epiderm graft, f/n/hf/g	Y	A2	$446.00	21.4302	$911.71	$562.43
15156	Cult epidrm grft f/n/hfg add	Y	A2	$333.00	21.4302	$911.71	$477.68
15157	Cult epiderm grft f/n/hfg +%	Y	A2	$333.00	21.4302	$911.71	$477.68
15200	Skin full graft, trunk	Y	A2	$510.00	14.0346	$597.07	$531.77
15201	Skin full graft trunk add-on	Y	A2	$323.28	5.2594	$223.75	$298.40
15220	Skin full graft sclp/arm/leg	Y	A2	$446.00	14.0346	$597.07	$483.77
15221	Skin full graft add-on	Y	A2	$323.28	5.2594	$223.75	$298.40
15240	Skin full grft face/genit/hf	Y	A2	$510.00	14.0346	$597.07	$531.77
15241	Skin full graft add-on	Y	A2	$323.28	5.2594	$223.75	$298.40
15260	Skin full graft een & lips	Y	A2	$446.00	14.0346	$597.07	$483.77
15261	Skin full graft add-on	Y	A2	$323.28	5.2594	$223.75	$298.40
15300	Apply skinallogrft, t/arm/lg	Y	A2	$323.28	5.2594	$223.75	$298.40
15301	Apply sknallogrft t/a/l addl	Y	A2	$323.28	5.2594	$223.75	$298.40
15320	Apply skin allogrft f/n/hf/g	Y	A2	$323.28	5.2594	$223.75	$298.40
15321	Aply sknallogrft f/n/hfg add	Y	A2	$323.28	5.2594	$223.75	$298.40
15330	Aply acell alogrft t/arm/leg	Y	A2	$323.28	5.2594	$223.75	$298.40
15331	Aply acell grft t/a/l add-on	Y	A2	$323.28	5.2594	$223.75	$298.40
15335	Apply acell graft, f/n/hf/g	Y	A2	$323.28	5.2594	$223.75	$298.40
15336	Aply acell grft f/n/hf/g add	Y	A2	$323.28	5.2594	$223.75	$298.40
15340	Apply cult skin substitute	Y	P3	.....	3.1385	$133.52	$133.52
15341	Apply cult skin sub add-on	Y	G2	.....	5.2594	$223.75	$223.75
15360	Apply cult derm sub, t/a/l	Y	G2	.....	5.2594	$223.75	$223.75
15361	Aply cult derm sub t/a/l add	Y	G2	.....	5.2594	$223.75	$223.75
15365	Apply cult derm sub f/n/hf/g	Y	G2	.....	5.2594	$223.75	$223.75
15366	Apply cult derm f/hf/g add	Y	G2	.....	5.2594	$223.75	$223.75
15400	Apply skin xenograft, t/a/l	Y	A2	$323.28	5.2594	$223.75	$298.40
15401	Apply skn xenogrft t/a/l add	Y	A2	$323.28	5.2594	$223.75	$298.40
15420	Apply skin xgraft, f/n/hf/g	Y	A2	$323.28	5.2594	$223.75	$298.40
15421	Apply skn xgrft f/n/hf/g add	Y	A2	$323.28	5.2594	$223.75	$298.40
15430	Apply acellular xenograft	Y	A2	$323.28	5.2594	$223.75	$298.40
15431	Apply acellular xgraft add	Y	A2	$323.28	5.2594	$223.75	$298.40
15570	Form skin pedicle flap	Y	A2	$510.00	21.4302	$911.71	$610.43
15572	Form skin pedicle flap	Y	A2	$510.00	21.4302	$911.71	$610.43
15574	Form skin pedicle flap	Y	A2	$510.00	21.4302	$911.71	$610.43
15576	Form skin pedicle flap	Y	A2	$510.00	14.0346	$597.07	$531.77
15600	Skin graft	Y	A2	$510.00	21.4302	$911.71	$610.43
15610	Skin graft	Y	A2	$510.00	21.4302	$911.71	$610.43
15620	Skin graft	Y	A2	$630.00	21.4302	$911.71	$700.43
15630	Skin graft	Y	A2	$510.00	21.4302	$911.71	$610.43

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
15650	Transfer skin pedicle flap	Y	A2	$717.00	21.4302	$911.71	$765.68
15731	Forehead flap w/vasc pedicle	Y	A2	$510.00	14.0346	$597.07	$531.77
15732	Muscle-skin graft, head/neck	Y	A2	$510.00	21.4302	$911.71	$610.43
15734	Muscle-skin graft, trunk	Y	A2	$510.00	21.4302	$911.71	$610.43
15736	Muscle-skin graft, arm	Y	A2	$510.00	21.4302	$911.71	$610.43
15738	Muscle-skin graft, leg	Y	A2	$510.00	21.4302	$911.71	$610.43
15740	Island pedicle flap graft	Y	A2	$446.00	14.0346	$597.07	$483.77
15750	Neurovascular pedicle graft	Y	A2	$446.00	21.4302	$911.71	$562.43
15760	Composite skin graft	Y	A2	$446.00	21.4302	$911.71	$562.43
15770	Derma-fat-fascia graft	Y	A2	$510.00	21.4302	$911.71	$610.43
15775	Hair transplant punch grafts	Y	A2	$323.28	5.2594	$223.75	$298.40
15776	Hair transplant punch grafts	Y	A2	$323.28	5.2594	$223.75	$298.40
15780	Abrasion treatment of skin	Y	P3	.....	9.3992	$399.87	$399.87
15781	Abrasion treatment of skin	Y	P2	.....	4.0919	$174.08	$174.08
15782	Abrasion treatment of skin	Y	P2	.....	4.0919	$174.08	$174.08
15783	Abrasion treatment of skin	Y	P2	.....	2.6749	$113.80	$113.80
15786	Abrasion, lesion, single	Y	P2	.....	1.0918	$46.45	$46.45
15787	Abrasion, lesions, add-on	Y	P3	.....	0.7726	$32.87	$32.87
15788	Chemical peel, face, epiderm	Y	P2	.....	0.8432	$35.87	$35.87
15789	Chemical peel, face, dermal	Y	P2	.....	1.6241	$69.09	$69.09
15792	Chemical peel, nonfacial	Y	P2	.....	1.0918	$46.45	$46.45
15793	Chemical peel, nonfacial	Y	P2	.....	0.8432	$35.87	$35.87
15819	Plastic surgery, neck	Y	G2	.....	5.2594	$223.75	$223.75
15820	Revision of lower eyelid	Y	A2	$510.00	21.4302	$911.71	$610.43
15821	Revision of lower eyelid	Y	A2	$510.00	21.4302	$911.71	$610.43
15822	Revision of upper eyelid	Y	A2	$510.00	21.4302	$911.71	$610.43
15823	Revision of upper eyelid	Y	A2	$717.00	14.0346	$597.07	$687.02
15824	Removal of forehead wrinkles	Y	A2	$510.00	21.4302	$911.71	$610.43
15825	Removal of neck wrinkles	Y	A2	$510.00	21.4302	$911.71	$610.43
15826	Removal of brow wrinkles	Y	A2	$510.00	21.4302	$911.71	$610.43
15828	Removal of face wrinkles	Y	A2	$510.00	21.4302	$911.71	$610.43
15829	Removal of skin wrinkles	Y	A2	$717.00	21.4302	$911.71	$765.68
15830	Exc skin abd	Y	A2	$510.00	20.0656	$853.65	$595.91
15832	Excise excessive skin tissue	Y	A2	$510.00	20.0656	$853.65	$595.91
15833	Excise excessive skin tissue	Y	A2	$510.00	20.0656	$853.65	$595.91
15834	Excise excessive skin tissue	Y	A2	$510.00	20.0656	$853.65	$595.91
15835	Excise excessive skin tissue	Y	A2	$323.28	5.2594	$223.75	$298.40
15836	Excise excessive skin tissue	Y	A2	$510.00	15.1024	$642.50	$543.13
15837	Excise excessive skin tissue	Y	G2	.....	15.1024	$642.50	$642.50
15838	Excise excessive skin tissue	Y	G2	.....	15.1024	$642.50	$642.50
15839	Excise excessive skin tissue	Y	A2	$510.00	15.1024	$642.50	$543.13
15840	Graft for face nerve palsy	Y	A2	$630.00	21.4302	$911.71	$700.43
15841	Graft for face nerve palsy	Y	A2	$630.00	21.4302	$911.71	$700.43
15842	Flap for face nerve palsy	Y	G2	.....	14.0346	$597.07	$597.07
15845	Skin and muscle repair, face	Y	A2	$630.00	21.4302	$911.71	$700.43
15847	Exc skin abd add-on	Y	A2	$510.00	20.0656	$853.65	$595.91
15850	Removal of sutures	Y	G2	.....	2.6749	$113.80	$113.80
15851	Removal of sutures	Y	P3	.....	1.2070	$51.35	$51.35
15852	Dressing change not for burn	N	G2	.....	0.6102	$25.96	$25.96
15860	Test for blood flow in graft	N	G2	.....	0.6102	$25.96	$25.96
15876	Suction assisted lipectomy	Y	A2	$510.00	21.4302	$911.71	$610.43
15877	Suction assisted lipectomy	Y	A2	$510.00	21.4302	$911.71	$610.43
15878	Suction assisted lipectomy	Y	A2	$510.00	14.0346	$597.07	$531.77
15879	Suction assisted lipectomy	Y	A2	$510.00	21.4302	$911.71	$610.43
15920	Removal of tail bone ulcer	Y	A2	$251.52	4.0919	$174.08	$232.16
15922	Removal of tail bone ulcer	Y	A2	$630.00	21.4302	$911.71	$700.43
15931	Remove sacrum pressure sore	Y	A2	$510.00	20.0656	$853.65	$595.91
15933	Remove sacrum pressure sore	Y	A2	$510.00	20.0656	$853.65	$595.91
15934	Remove sacrum pressure sore	Y	A2	$510.00	21.4302	$911.71	$610.43
15935	Remove sacrum pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
15936	Remove sacrum pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
15937	Remove sacrum pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
15940	Remove hip pressure sore	Y	A2	$510.00	20.0656	$853.65	$595.91

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
15941	Remove hip pressure sore	Y	A2	$510.00	20.0656	$853.65	$595.91
15944	Remove hip pressure sore	Y	A2	$510.00	21.4302	$911.71	$610.43
15945	Remove hip pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
15946	Remove hip pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
15950	Remove thigh pressure sore	Y	A2	$510.00	20.0656	$853.65	$595.91
15951	Remove thigh pressure sore	Y	A2	$630.00	20.0656	$853.65	$685.91
15952	Remove thigh pressure sore	Y	A2	$510.00	21.4302	$911.71	$610.43
15953	Remove thigh pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
15956	Remove thigh pressure sore	Y	A2	$510.00	21.4302	$911.71	$610.43
15958	Remove thigh pressure sore	Y	A2	$630.00	21.4302	$911.71	$700.43
16000	Initial treatment of burn(s)	Y	P3		0.6438	$27.39	$27.39
16020	Dress/debrid p-thick burn, s	Y	P3		0.9656	$41.08	$41.08
16025	Dress/debrid p-thick burn, m	Y	A2	$67.11	1.0918	$46.45	$61.95
16030	Dress/debrid p-thick burn, l	Y	A2	$99.83	1.6241	$69.09	$92.15
16035	Incision of burn scab, initi	Y	G2		2.6749	$113.80	$113.80
17000	Destruct premalg lesion	Y	P2		0.4760	$20.25	$20.25
17003	Destruct premalg les, 2–14	Y	P3		0.0886	$3.77	$3.77
17004	Destroy premlg lesions 15+	Y	P3		1.8993	$80.80	$80.80
17106	Destruction of skin lesions	Y	P2		2.5665	$109.19	$109.19
17107	Destruction of skin lesions	Y	P2		2.5665	$109.19	$109.19
17108	Destruction of skin lesions	Y	P2		2.5665	$109.19	$109.19
17110	Destruct b9 lesion, 1–14	Y	P2		0.8432	$35.87	$35.87
17111	Destruct lesion, 15 or more	Y	P2		1.0918	$46.45	$46.45
17250	Chemical cautery, tissue	Y	P3		1.0220	$43.48	$43.48
17260	Destruction of skin lesions	Y	P3		1.0944	$46.56	$46.56
17261	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17262	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17263	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17264	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17266	Destruction of skin lesions	Y	P3		2.4382	$103.73	$103.73
17270	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17271	Destruction of skin lesions	Y	P2		1.0918	$46.45	$46.45
17272	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17273	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17274	Destruction of skin lesions	Y	P3		2.5026	$106.47	$106.47
17276	Destruction of skin lesions	Y	P2		2.6749	$113.80	$113.80
17280	Destruction of skin lesions	Y	P3		1.6014	$68.13	$68.13
17281	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17282	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17283	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17284	Destruction of skin lesions	Y	P2		2.6749	$113.80	$113.80
17286	Destruction of skin lesions	Y	P2		1.6241	$69.09	$69.09
17311	Mohs, 1 stage, h/n/hf/g	Y	P2		3.7292	$158.65	$158.65
17312	Mohs addl stage	Y	P2		3.7292	$158.65	$158.65
17313	Mohs, 1 stage, t/a/l	Y	P2		3.7292	$158.65	$158.65
17314	Mohs, addl stage, t/a/l	Y	P2		3.7292	$158.65	$158.65
17315	Mohs surg, addl block	Y	P3		0.9254	$39.37	$39.37
17340	Cryotherapy of skin	Y	P3		0.2816	$11.98	$11.98
17360	Skin peel therapy	Y	P2		1.0918	$46.45	$46.45
17380	Hair removal by electrolysis	Y	R2		1.0918	$46.45	$46.45
19000	Drainage of breast lesion	Y	P3		1.5290	$65.05	$65.05
19001	Drain breast lesion add-on	Y	P3		0.1932	$8.22	$8.22
19020	Incision of breast lesion	Y	A2	$446.00	17.5086	$744.87	$520.72
19030	Injection for breast x-ray		N1				
19100	Bx breast percut w/o image	Y	A2	$240.00	3.9045	$166.11	$221.53
19101	Biopsy of breast, open	Y	A2	$446.00	19.2788	$820.18	$539.55
19102	Bx breast percut w/image	Y	A2	$240.00	3.9045	$166.11	$221.53
19103	Bx breast percut w/device	Y	A2	$395.77	6.4387	$273.92	$365.31
19105	Cryosurg ablate fa, each	Y	G2		28.0166	$1,191.91	$1,191.91
19110	Nipple exploration	Y	A2	$446.00	19.2788	$820.18	$539.55
19112	Excise breast duct fistula	Y	A2	$510.00	19.2788	$820.18	$587.55
19120	Removal of breast lesion	Y	A2	$510.00	19.2788	$820.18	$587.55
19125	Excision, breast lesion	Y	A2	$510.00	19.2788	$820.18	$587.55

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
19126	Excision, addl breast lesion	Y	A2	$510.00	19.2788	$820.18	$587.55
19290	Place needle wire, breast		N1	$333.00			
19291	Place needle wire, breast		N1	$333.00			
19295	Place breast clip, percut	N	A2	$106.76	1.7369	$73.89	$98.54
19296	Place po breast cath for rad	Y	A2	$1,339.00	51.2269	$2,179.35	$1,549.09
19297	Place breast cath for rad	Y	A2	$1,339.00	51.2269	$2,179.35	$1,549.09
19298	Place breast rad tube/caths	N	A2	$1,339.00	52.8730	$2,249.38	$1,566.60
19300	Removal of breast tissue	Y	A2	$630.00	19.2788	$820.18	$677.55
19301	Partical mastectomy	Y	A2	$510.00	19.2788	$820.18	$587.55
19302	P-mastectomy w/ln removal	Y	A2	$995.00	36.9988	$1,574.04	$1,139.76
19303	Mast, simple, complete	Y	A2	$630.00	28.0166	$1,191.91	$770.48
19304	Mast, subq	Y	A2	$630.00	28.0166	$1,191.91	$770.48
19316	Suspension of breast	Y	A2	$630.00	28.0166	$1,191.91	$770.48
19318	Reduction of large breast	Y	A2	$630.00	36.9988	$1,574.04	$866.01
19324	Enlarge breast	Y	A2	$630.00	36.9988	$1,574.04	$866.01
19325	Enlarge breast with implant	Y	A2	$1,339.00	51.2269	$2,179.35	$1,549.09
19328	Removal of breast implant	Y	A2	$333.00	28.0166	$1,191.91	$547.73
19330	Removal of implant material	Y	A2	$333.00	28.0166	$1,191.91	$547.73
19340	Immediate breast prosthesis	Y	A2	$446.00	37.8692	$1,611.07	$737.27
19342	Delayed breast prosthesis	Y	A2	$510.00	51.2269	$2,179.35	$927.34
19350	Breast reconstruction	Y	A2	$630.00	19.2788	$820.18	$677.55
19355	Correct inverted nipple(s)	Y	A2	$630.00	28.0166	$1,191.91	$770.48
19357	Breast reconstruction	Y	A2	$717.00	51.2269	$2,179.35	$1,082.59
19366	Breast reconstruction	Y	A2	$717.00	28.0166	$1,191.91	$835.73
19370	Surgery of breast capsule	Y	A2	$630.00	28.0166	$1,191.91	$770.48
19371	Removal of breast capsule	Y	A2	$630.00	28.0166	$1,191.91	$770.48
19380	Revise breast reconstruction	Y	A2	$717.00	37.8692	$1,611.07	$940.52
19396	Design custom breast implant	Y	G2		28.0166	$1,191.91	$1,191.91
20000	Incision of abscess	Y	P2		1.4392	$61.23	$61.23
20005	Incision of deep abscess	Y	A2	$446.00	20.8706	$887.90	$556.48
20103	Explore wound, extremity	Y	G2		4.2212	$179.58	$179.58
20150	Excise epiphyseal bar	Y	G2		41.0893	$1,748.06	$1,748.06
20200	Muscle biopsy	Y	A2	$446.00	15.1024	$642.50	$495.13
20205	Deep muscle biopsy	Y	A2	$510.00	15.1024	$642.50	$543.13
20206	Needle biopsy, muscle	Y	A2	$240.00	3.9045	$166.11	$221.53
20220	Bone biopsy, trocar/needle	Y	A2	$251.52	4.0919	$174.08	$232.16
20225	Bone biopsy, trocar/needle	Y	A2	$418.49	6.8083	$289.65	$386.28
20240	Bone biopsy, excisional	Y	A2	$446.00	20.0656	$853.65	$547.91
20245	Bone biopsy, excisional	Y	A2	$510.00	20.0656	$853.65	$595.91
20250	Open bone biopsy	Y	A2	$510.00	20.8706	$887.90	$604.48
20251	Open bone biopsy	Y	A2	$510.00	20.8706	$887.90	$604.48
20500	Injection of sinus tract	Y	P3		1.4162	$60.25	$60.25
20501	Inject sinus tract for x-ray		N1				
20520	Removal of foreign body	Y	P3		2.2131	$94.15	$94.15
20525	Removal of foreign body	Y	A2	$510.00	20.0656	$853.65	$595.91
20526	Ther injection, carp tunnel	Y	P3		0.7162	$30.47	$30.47
20550	Inj tendon sheath/ligament	Y	P3		0.5392	$22.94	$22.94
20551	Inj tendon origin/insertion	Y	P3		0.5312	$22.60	$22.60
20552	Inj trigger point, 1/2 muscl	Y	P3		0.5230	$22.25	$22.25
20553	Inject trigger points, =/> 3	Y	P3		0.5874	$24.99	$24.99
20600	Drain/inject, joint/bursa	Y	P3		0.5312	$22.60	$22.60
20605	Drain/inject, joint/bursa	Y	P3		0.6036	$25.68	$25.68
20610	Drain/inject, joint/bursa	Y	P3		0.8128	$34.58	$34.58
20612	Aspirate/inj ganglion cyst	Y	P3		0.5714	$24.31	$24.31
20615	Treatment of bone cyst	Y	P2		2.0687	$88.01	$88.01
20650	Insert and remove bone pin	Y	A2	$510.00	20.8706	$887.90	$604.48
20662	Application of pelvis brace	Y	R2		20.8706	$887.90	$887.90
20663	Application of thigh brace	Y	R2		20.8706	$887.90	$887.90
20665	Removal of fixation device	N	G2		0.6102	$25.96	$25.96
20670	Removal of support implant	Y	A2	$333.00	15.1024	$642.50	$410.38
20680	Removal of support implant	Y	A2	$510.00	20.0656	$853.65	$595.91
20690	Apply bone fixation device	Y	A2	$446.00	25.1296	$1,069.09	$601.77
20692	Apply bone fixation device	Y	A2	$510.00	25.1296	$1,069.09	$649.77

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
20693	Adjust bone fixation device	Y	A2	$510.00	20.8706	$887.90	$604.48
20694	Remove bone fixation device	Y	A2	$333.00	20.8706	$887.90	$471.73
20822	Replantation digit, complete	Y	G2		25.8758	$1,100.83	$1,100.83
20900	Removal of bone for graft	Y	A2	$510.00	25.1296	$1,069.09	$649.77
20902	Removal of bone for graft	Y	A2	$630.00	25.1296	$1,069.09	$739.77
20910	Remove cartilage for graft	Y	A2	$510.00	21.4302	$911.71	$610.43
20912	Remove cartilage for graft	Y	A2	$510.00	21.4302	$911.71	$610.43
20920	Removal of fascia for graft	Y	A2	$630.00	14.0346	$597.07	$621.77
20922	Removal of fascia for graft	Y	A2	$510.00	21.4302	$911.71	$610.43
20924	Removal of tendon for graft	Y	A2	$630.00	25.1296	$1,069.09	$739.77
20926	Removal of tissue for graft	Y	A2	$630.00	14.0346	$597.07	$621.77
20950	Fluid pressure, muscle	Y	G2		1.4392	$61.23	$61.23
20972	Bone/skin graft, metatarsal	Y	G2		40.8559	$1,738.13	$1,738.13
20973	Bone/skin graft, great toe	Y	R2		40.8559	$1,738.13	$1,738.13
20975	Electrical bone stimulation	N	A2	$37.51	0.6102	$25.96	$34.62
20979	Us bone stimulation	N	P3		0.5552	$23.62	$23.62
20982	Ablate, bone tumor(s) perq	Y	G2		41.0893	$1,748.06	$1,748.06
21010	Incision of jaw joint	Y	A2	$446.00	23.3299	$992.52	$582.63
21015	Resection of facial tumor	Y	A2	$510.00	16.4266	$698.84	$557.21
21025	Excision of bone, lower jaw	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21026	Excision of facial bone(s)	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21029	Contour of face bone lesion	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21030	Excise max/zygoma b9 tumor	Y	P3		5.4479	$231.77	$231.77
21031	Remove exostosis, mandible	Y	P3		4.4823	$190.69	$190.69
21032	Remove exostosis, maxilla	Y	P3		4.5869	$195.14	$195.14
21034	Excise max/zygoma mlg tumor	Y	A2	$510.00	38.1991	$1,625.10	$788.78
21040	Excise mandible lesion	Y	A2	$446.00	23.3299	$992.52	$582.63
21044	Removal of jaw bone lesion	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21046	Remove mandible cyst complex	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21047	Excise lwr jaw cyst w/repair	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21048	Remove maxilla cyst complex	Y	R2		38.1991	$1,625.10	$1,625.10
21050	Removal of jaw joint	Y	A2	$510.00	38.1991	$1,625.10	$788.78
21060	Remove jaw joint cartilage	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21070	Remove coronoid process	Y	A2	$510.00	38.1991	$1,625.10	$788.78
21076	Prepare face/oral prosthesis	Y	P3		8.1760	$347.83	$347.83
21077	Prepare face/oral prosthesis	Y	P3		20.1504	$857.26	$857.26
21079	Prepare face/oral prosthesis	Y	P3		14.2437	$605.97	$605.97
21080	Prepare face/oral prosthesis	Y	P3		16.3280	$694.64	$694.64
21081	Prepare face/oral prosthesis	Y	P3		14.9437	$635.75	$635.75
21082	Prepare face/oral prosthesis	Y	P3		13.8253	$588.17	$588.17
21083	Prepare face/oral prosthesis	Y	P3		13.5113	$574.81	$574.81
21084	Prepare face/oral prosthesis	Y	P3		15.6117	$664.17	$664.17
21085	Prepare face/oral prosthesis	Y	P3		6.1079	$259.85	$259.85
21086	Prepare face/oral prosthesis	Y	P3		14.7587	$627.88	$627.88
21087	Prepare face/oral prosthesis	Y	P3		14.6621	$623.77	$623.77
21088	Prepare face/oral prosthesis	Y	R2		38.1991	$1,625.10	$1,625.10
21100	Maxillofacial fixation	Y	A2	$446.00	38.1991	$1,625.10	$740.78
21110	Interdental fixation	Y	P2		7.5511	$321.25	$321.25
21116	Injection, jaw joint x-ray		N1				
21120	Reconstruction of chin	Y	A2	$995.00	23.3299	$992.52	$994.38
21121	Reconstruction of chin	Y	A2	$995.00	23.3299	$992.52	$994.38
21122	Reconstruction of chin	Y	A2	$995.00	23.3299	$992.52	$994.38
21123	Reconstruction of chin	Y	A2	$995.00	23.3299	$992.52	$994.38
21125	Augmentation, lower jaw bone	Y	A2	$995.00	23.3299	$992.52	$994.38
21127	Augmentation, lower jaw bone	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
21137	Reduction of forehead	Y	G2		23.3299	$992.52	$992.52
21138	Reduction of forehead	Y	G2		38.1991	$1,625.10	$1,625.10
21139	Reduction of forehead	Y	G2		38.1991	$1,625.10	$1,625.10
21150	Reconstruct midface, lefort	Y	G2		38.1991	$1,625.10	$1,625.10
21181	Contour cranial bone lesion	Y	A2	$995.00	23.3299	$992.52	$994.38
21198	Reconstr lwr jaw segment	Y	G2		38.1991	$1,625.10	$1,625.10
21199	Reconstr lwr jaw w/advance	Y	G2		38.1991	$1,625.10	$1,625.10
21206	Reconstruct upper jaw bone	Y	A2	$717.00	38.1991	$1,625.10	$944.03

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
21208	Augmentation of facial bones	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21209	Reduction of facial bones	Y	A2	$717.00	38.1991	$1,625.10	$944.03
21210	Face bone graft	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21215	Lower jaw bone graft	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21230	Rib cartilage graft	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21235	Ear cartilage graft	Y	A2	$995.00	23.3299	$992.52	$994.38
21240	Reconstruction of jaw joint	Y	A2	$630.00	38.1991	$1,625.10	$878.78
21242	Reconstruction of jaw joint	Y	A2	$717.00	38.1991	$1,625.10	$944.03
21243	Reconstruction of jaw joint	Y	A2	$717.00	38.1991	$1,625.10	$944.03
21244	Reconstruction of lower jaw	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21245	Reconstruction of jaw	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21246	Reconstruction of jaw	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21248	Reconstruction of jaw	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21249	Reconstruction of jaw	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21260	Revise eye sockets	Y	G2	.....	38.1991	$1,625.10	$1,625.10
21267	Revise eye sockets	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21270	Augmentation, cheek bone	Y	A2	$717.00	38.1991	$1,625.10	$944.03
21275	Revision, orbitofacial bones	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
21280	Revision of eyelid	Y	A2	$717.00	38.1991	$1,625.10	$944.03
21282	Revision of eyelid	Y	A2	$717.00	16.4266	$698.84	$712.46
21295	Revision of jaw muscle/bone	Y	A2	$333.00	7.5511	$321.25	$330.06
21296	Revision of jaw muscle/bone	Y	A2	$333.00	23.3299	$992.52	$497.88
21310	Treatment of nose fracture	Y	A2	$150.72	2.4520	$104.32	$139.12
21315	Treatment of nose fracture	Y	A2	$150.72	2.4520	$104.32	$139.12
21320	Treatment of nose fracture	Y	A2	$446.00	7.5511	$321.25	$414.81
21325	Treatment of nose fracture	Y	A2	$630.00	23.3299	$992.52	$720.63
21330	Treatment of nose fracture	Y	A2	$717.00	23.3299	$992.52	$785.88
21335	Treatment of nose fracture	Y	A2	$995.00	23.3299	$992.52	$994.38
21336	Treat nasal septal fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75
21337	Treat nasal septal fracture	Y	A2	$446.00	16.4266	$698.84	$509.21
21338	Treat nasoethmoid fracture	Y	A2	$630.00	23.3299	$992.52	$720.63
21339	Treat nasoethmoid fracture	Y	A2	$717.00	23.3299	$992.52	$785.88
21340	Treatment of nose fracture	Y	A2	$630.00	38.1991	$1,625.10	$878.78
21345	Treat nose/jaw fracture	Y	A2	$995.00	23.3299	$992.52	$994.38
21355	Treat cheek bone fracture	Y	A2	$510.00	38.1991	$1,625.10	$788.78
21356	Treat cheek bone fracture	Y	A2	$510.00	23.3299	$992.52	$630.63
21390	Treat eye socket fracture	Y	G2	.....	38.1991	$1,625.10	$1,625.10
21400	Treat eye socket fracture	Y	A2	$446.00	7.5511	$321.25	$414.81
21401	Treat eye socket fracture	Y	A2	$510.00	16.4266	$698.84	$557.21
21406	Treat eye socket fracture	Y	G2	.....	38.1991	$1,625.10	$1,625.10
21407	Treat eye socket fracture	Y	G2	.....	38.1991	$1,625.10	$1,625.10
21421	Treat mouth roof fracture	Y	A2	$630.00	23.3299	$992.52	$720.63
21440	Treat dental ridge fracture	Y	P3	.....	7.0012	$297.85	$297.85
21445	Treat dental ridge fracture	Y	A2	$630.00	23.3299	$992.52	$720.63
21450	Treat lower jaw fracture	Y	A2	$150.72	2.4520	$104.32	$139.12
21451	Treat lower jaw fracture	Y	A2	$464.15	7.5511	$321.25	$428.43
21452	Treat lower jaw fracture	Y	A2	$446.00	16.4266	$698.84	$509.21
21453	Treat lower jaw fracture	Y	A2	$510.00	38.1991	$1,625.10	$788.78
21454	Treat lower jaw fracture	Y	A2	$717.00	23.3299	$992.52	$785.88
21461	Treat lower jaw fracture	Y	A2	$630.00	38.1991	$1,625.10	$878.78
21462	Treat lower jaw fracture	Y	A2	$717.00	38.1991	$1,625.10	$944.03
21465	Treat lower jaw fracture	Y	A2	$630.00	38.1991	$1,625.10	$878.78
21480	Reset dislocated jaw	Y	A2	$150.72	2.4520	$104.32	$139.12
21485	Reset dislocated jaw	Y	A2	$446.00	16.4266	$698.84	$509.21
21490	Repair dislocated jaw	Y	A2	$510.00	38.1991	$1,625.10	$788.78
21495	Treat hyoid bone fracture	Y	G2	.....	16.4266	$698.84	$698.84
21497	Interdental wiring	Y	A2	$446.00	16.4266	$698.84	$509.21
21501	Drain neck/chest lesion	Y	A2	$446.00	17.5086	$744.87	$520.72
21502	Drain chest lesion	Y	A2	$446.00	20.8706	$887.90	$556.48
21550	Biopsy of neck/chest	Y	G2	.....	6.8083	$289.65	$289.65
21555	Remove lesion, neck/chest	Y	A2	$446.00	20.0656	$853.65	$547.91
21556	Remove lesion, neck/chest	Y	A2	$446.00	20.0656	$853.65	$547.91
21557	Remove tumor, neck/chest	Y	G2	.....	20.0656	$853.65	$853.65

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
21600	Partial removal of rib	Y	A2	$446.00	25.1296	$1,069.09	$601.77
21610	Partial removal of rib	Y	A2	$446.00	25.1296	$1,069.09	$601.77
21685	Hyoid myotomy & suspension	Y	G2	.....	7.5511	$321.25	$321.25
21700	Revision of neck muscle	Y	A2	$446.00	20.8706	$887.90	$556.48
21720	Revision of neck muscle	Y	A2	$510.00	20.8706	$887.90	$604.48
21725	Revision of neck muscle	Y	A2	$88.46	1.4392	$61.23	$81.65
21800	Treatment of rib fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
21805	Treatment of rib fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
21820	Treat sternum fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
21920	Biopsy soft tissue of back	Y	P3	.....	3.0983	$131.81	$131.81
21925	Biopsy soft tissue of back	Y	A2	$446.00	20.0656	$853.65	$547.91
21930	Remove lesion, back or flank	Y	A2	$446.00	20.0656	$853.65	$547.91
21935	Remove tumor, back	Y	A2	$510.00	20.0656	$853.65	$595.91
22102	Remove part, lumbar vertebra	Y	G2	.....	44.1489	$1,878.23	$1,878.23
22103	Remove extra spine segment	Y	G2	.....	44.1489	$1,878.23	$1,878.23
22305	Treat spine process fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
22310	Treat spine fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
22315	Treat spine fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
22505	Manipulation of spine	Y	A2	$446.00	14.5947	$620.90	$489.73
22520	Percut vertebroplasty thor	Y	A2	$1,339.00	25.1296	$1,069.09	$1,271.52
22521	Percut vertebroplasty lumb	Y	A2	$1,339.00	25.1296	$1,069.09	$1,271.52
22522	Percut vertebroplasty add-on	Y	A2	$1,339.00	25.1296	$1,069.09	$1,271.52
22523	Percut kyphoplasty, thor	Y	G2	.....	66.5800	$2,832.51	$2,832.51
22524	Percut kyphoplasty, lumbar	Y	G2	.....	66.5800	$2,832.51	$2,832.51
22525	Percut kyphoplasty, add-on	Y	G2	.....	66.5800	$2,832.51	$2,832.51
22900	Remove abdominal wall lesion	Y	A2	$630.00	20.0656	$853.65	$685.91
23000	Removal of calcium deposits	Y	A2	$446.00	15.1024	$642.50	$495.13
23020	Release shoulder joint	Y	A2	$446.00	41.0893	$1,748.06	$771.52
23030	Drain shoulder lesion	Y	A2	$333.00	17.5086	$744.87	$435.97
23031	Drain shoulder bursa	Y	A2	$510.00	17.5086	$744.87	$568.72
23035	Drain shoulder bone lesion	Y	A2	$510.00	20.8706	$887.90	$604.48
23040	Exploratory shoulder surgery	Y	A2	$510.00	25.1296	$1,069.09	$649.77
23044	Exploratory shoulder surgery	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23065	Biopsy shoulder tissues	Y	P3	.....	2.1888	$93.12	$93.12
23066	Biopsy shoulder tissues	Y	A2	$446.00	20.0656	$853.65	$547.91
23075	Removal of shoulder lesion	Y	A2	$446.00	15.1024	$642.50	$495.13
23076	Removal of shoulder lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
23077	Remove tumor of shoulder	Y	A2	$510.00	20.0656	$853.65	$595.91
23100	Biopsy of shoulder joint	Y	A2	$446.00	20.8706	$887.90	$556.48
23101	Shoulder joint surgery	Y	A2	$995.00	25.1296	$1,069.09	$1,013.52
23105	Remove shoulder joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23106	Incision of collarbone joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23107	Explore treat shoulder joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23120	Partial removal, collar bone	Y	A2	$717.00	41.0893	$1,748.06	$974.77
23125	Removal of collar bone	Y	A2	$717.00	41.0893	$1,748.06	$974.77
23130	Remove shoulder bone, part	Y	A2	$717.00	41.0893	$1,748.06	$974.77
23140	Removal of bone lesion	Y	A2	$630.00	20.8706	$887.90	$694.48
23145	Removal of bone lesion	Y	A2	$717.00	25.1296	$1,069.09	$805.02
23146	Removal of bone lesion	Y	A2	$717.00	25.1296	$1,069.09	$805.02
23150	Removal of humerus lesion	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23155	Removal of humerus lesion	Y	A2	$717.00	25.1296	$1,069.09	$805.02
23156	Removal of humerus lesion	Y	A2	$717.00	25.1296	$1,069.09	$805.02
23170	Remove collar bone lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
23172	Remove shoulder blade lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
23174	Remove humerus lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
23180	Remove collar bone lesion	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23182	Remove shoulder blade lesion	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23184	Remove humerus lesion	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23190	Partial removal of scapula	Y	A2	$630.00	25.1296	$1,069.09	$739.77
23195	Removal of head of humerus	Y	A2	$717.00	25.1296	$1,069.09	$805.02
23330	Remove shoulder foreign body	Y	A2	$333.00	6.8083	$289.65	$322.16
23331	Remove shoulder foreign body	Y	A2	$333.00	20.0656	$853.65	$463.16
23350	Injection for shoulder x-ray	.....	N1	.....	.....	.....	.....

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
23395	Muscle transfer,shoulder/arm	Y	A2	$717.00	41.0893	$1,748.06	$974.77
23397	Muscle transfers	Y	A2	$995.00	66.5800	$2,832.51	$1,454.38
23400	Fixation of shoulder blade	Y	A2	$995.00	25.1296	$1,069.09	$1,013.52
23405	Incision of tendon & muscle	Y	A2	$446.00	25.1296	$1,069.09	$601.77
23406	Incise tendon(s) & muscle(s)	Y	A2	$446.00	25.1296	$1,069.09	$601.77
23410	Repair rotator cuff, acute	Y	A2	$717.00	41.0893	$1,748.06	$974.77
23412	Repair rotator cuff, chronic	Y	A2	$995.00	41.0893	$1,748.06	$1,183.27
23415	Release of shoulder ligament	Y	A2	$717.00	41.0893	$1,748.06	$974.77
23420	Repair of shoulder	Y	A2	$995.00	41.0893	$1,748.06	$1,183.27
23430	Repair biceps tendon	Y	A2	$630.00	41.0893	$1,748.06	$909.52
23440	Remove/transplant tendon	Y	A2	$630.00	41.0893	$1,748.06	$909.52
23450	Repair shoulder capsule	Y	A2	$717.00	66.5800	$2,832.51	$1,245.88
23455	Repair shoulder capsule	Y	A2	$995.00	66.5800	$2,832.51	$1,454.38
23460	Repair shoulder capsule	Y	A2	$717.00	66.5800	$2,832.51	$1,245.88
23462	Repair shoulder capsule	Y	A2	$995.00	41.0893	$1,748.06	$1,183.27
23465	Repair shoulder capsule	Y	A2	$717.00	66.5800	$2,832.51	$1,245.88
23466	Repair shoulder capsule	Y	A2	$995.00	41.0893	$1,748.06	$1,183.27
23480	Revision of collar bone	Y	A2	$630.00	41.0893	$1,748.06	$909.52
23485	Revision of collar bone	Y	A2	$995.00	66.5800	$2,832.51	$1,454.38
23490	Reinforce clavicle	Y	A2	$510.00	41.0893	$1,748.06	$819.52
23491	Reinforce shoulder bones	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
23500	Treat clavicle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
23505	Treat clavicle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
23515	Treat clavicle fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
23520	Treat clavicle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
23525	Treat clavicle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
23530	Treat clavicle dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
23532	Treat clavicle dislocation	Y	A2	$630.00	25.5264	$1,085.97	$743.99
23540	Treat clavicle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
23545	Treat clavicle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
23550	Treat clavicle dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
23552	Treat clavicle dislocation	Y	A2	$630.00	37.5382	$1,596.99	$871.75
23570	Treat shoulder blade fx	Y	A2	$103.62	1.6857	$71.71	$95.64
23575	Treat shoulder blade fx	Y	A2	$103.62	1.6857	$71.71	$95.64
23585	Treat scapula fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
23600	Treat humerus fracture	Y	P2	.....	1.6857	$71.71	$71.71
23605	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
23615	Treat humerus fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
23616	Treat humerus fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
23620	Treat humerus fracture	Y	P2	.....	1.6857	$71.71	$71.71
23625	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
23630	Treat humerus fracture	Y	A2	$717.00	57.2172	$2,434.19	$1,146.30
23650	Treat shoulder dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
23655	Treat shoulder dislocation	Y	A2	$333.00	14.5947	$620.90	$404.98
23660	Treat shoulder dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
23665	Treat dislocation/fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
23670	Treat dislocation/fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
23675	Treat dislocation/fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
23680	Treat dislocation/fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
23700	Fixation of shoulder	Y	A2	$333.00	14.5947	$620.90	$404.98
23800	Fusion of shoulder joint	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
23802	Fusion of shoulder joint	Y	A2	$995.00	41.0893	$1,748.06	$1,183.27
23921	Amputation follow-up surgery	Y	A2	$323.28	5.2594	$223.75	$298.40
23930	Drainage of arm lesion	Y	A2	$333.00	17.5086	$744.87	$435.97
23931	Drainage of arm bursa	Y	A2	$446.00	17.5086	$744.87	$520.72
23935	Drain arm/elbow bone lesion	Y	A2	$446.00	20.8706	$887.90	$556.48
24000	Exploratory elbow surgery	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24006	Release elbow joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24065	Biopsy arm/elbow soft tissue	Y	P3	.....	2.9695	$126.33	$126.33
24066	Biopsy arm/elbow soft tissue	Y	A2	$446.00	15.1024	$642.50	$495.13
24075	Remove arm/elbow lesion	Y	A2	$446.00	15.1024	$642.50	$495.13
24076	Remove arm/elbow lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
24077	Remove tumor of arm/elbow	Y	A2	$510.00	20.0656	$853.65	$595.91

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
24100	Biopsy elbow joint lining	Y	A2	$333.00	20.8706	$887.90	$471.73
24101	Explore/treat elbow joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24102	Remove elbow joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24105	Removal of elbow bursa	Y	A2	$510.00	20.8706	$887.90	$604.48
24110	Remove humerus lesion	Y	A2	$446.00	20.8706	$887.90	$556.48
24115	Remove/graft bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24116	Remove/graft bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24120	Remove elbow lesion	Y	A2	$510.00	20.8706	$887.90	$604.48
24125	Remove/graft bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24126	Remove/graft bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24130	Removal of head of radius	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24134	Removal of arm bone lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24136	Remove radius bone lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24138	Remove elbow bone lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24140	Partial removal of arm bone	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24145	Partial removal of radius	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24147	Partial removal of elbow	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24149	Radical resection of elbow	Y	G2	.....	25.1296	$1,069.09	$1,069.09
24152	Extensive radius surgery	Y	G2	.....	41.0893	$1,748.06	$1,748.06
24153	Extensive radius surgery	Y	G2	.....	66.5800	$2,832.51	$2,832.51
24155	Removal of elbow joint	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24160	Remove elbow joint implant	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24164	Remove radius head implant	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24200	Removal of arm foreign body	Y	P3	.....	2.4867	$105.79	$105.79
24201	Removal of arm foreign body	Y	A2	$446.00	15.1024	$642.50	$495.13
24220	Injection for elbow x-ray		N1	.....	.....	.....	.....
24300	Manipulate elbow w/anesth	Y	G2	.....	14.5947	$620.90	$620.90
24301	Muscle/tendon transfer	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24305	Arm tendon lengthening	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24310	Revision of arm tendon	Y	A2	$510.00	20.8706	$887.90	$604.48
24320	Repair of arm tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24330	Revision of arm muscles	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
24331	Revision of arm muscles	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24332	Tenolysis, triceps	Y	G2	.....	20.8706	$887.90	$887.90
24340	Repair of biceps tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24341	Repair arm tendon/muscle	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24342	Repair of ruptured tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24343	Repr elbow lat ligmnt w/tiss	Y	G2	.....	25.1296	$1,069.09	$1,069.09
24344	Reconstruct elbow lat ligmnt	Y	G2	.....	66.5800	$2,832.51	$2,832.51
24345	Repr elbw med ligmnt w/tissu	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24346	Reconstruct elbow med ligmnt	Y	G2	.....	41.0893	$1,748.06	$1,748.06
24350	Repair of tennis elbow	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24351	Repair of tennis elbow	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24352	Repair of tennis elbow	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24354	Repair of tennis elbow	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24356	Revision of tennis elbow	Y	A2	$510.00	25.1296	$1,069.09	$649.77
24360	Reconstruct elbow joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
24361	Reconstruct elbow joint	Y	A2	$717.00	107.1942	$4,560.36	$1,677.84
24362	Reconstruct elbow joint	Y	A2	$717.00	47.4378	$2,018.15	$1,042.29
24363	Replace elbow joint	Y	A2	$995.00	107.1942	$4,560.36	$1,886.34
24365	Reconstruct head of radius	Y	A2	$717.00	33.4505	$1,423.08	$893.52
24366	Reconstruct head of radius	Y	A2	$717.00	107.1942	$4,560.36	$1,677.84
24400	Revision of humerus	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24410	Revision of humerus	Y	A2	$630.00	25.1296	$1,069.09	$739.77
24420	Revision of humerus	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24430	Repair of humerus	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
24435	Repair humerus with graft	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
24470	Revision of elbow joint	Y	A2	$510.00	41.0893	$1,748.06	$819.52
24495	Decompression of forearm	Y	A2	$446.00	25.1296	$1,069.09	$601.77
24498	Reinforce humerus	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
24500	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24505	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24515	Treat humerus fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
24516	Treat humerus fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
24530	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24535	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24538	Treat humerus fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
24545	Treat humerus fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
24546	Treat humerus fracture	Y	A2	$717.00	57.2172	$2,434.19	$1,146.30
24560	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24565	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24566	Treat humerus fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
24575	Treat humerus fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
24576	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24577	Treat humerus fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24579	Treat humerus fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
24582	Treat humerus fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
24586	Treat elbow fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
24587	Treat elbow fracture	Y	A2	$717.00	57.2172	$2,434.19	$1,146.30
24600	Treat elbow dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
24605	Treat elbow dislocation	Y	A2	$446.00	14.5947	$620.90	$489.73
24615	Treat elbow dislocation	Y	A2	$510.00	57.2172	$2,434.19	$991.05
24620	Treat elbow fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24635	Treat elbow fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
24640	Treat elbow dislocation	Y	G2	.....	1.6857	$71.71	$71.71
24650	Treat radius fracture	Y	P2	.....	1.6857	$71.71	$71.71
24655	Treat radius fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24665	Treat radius fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75
24666	Treat radius fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
24670	Treat ulnar fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24675	Treat ulnar fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
24685	Treat ulnar fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
24800	Fusion of elbow joint	Y	A2	$630.00	41.0893	$1,748.06	$909.52
24802	Fusion/graft of elbow joint	Y	A2	$717.00	41.0893	$1,748.06	$974.77
24925	Amputation follow-up surgery	Y	A2	$510.00	20.8706	$887.90	$604.48
25000	Incision of tendon sheath	Y	A2	$510.00	20.8706	$887.90	$604.48
25001	Incise flexor carpi radialis	Y	G2	.....	20.8706	$887.90	$887.90
25020	Decompress forearm 1 space	Y	A2	$510.00	20.8706	$887.90	$604.48
25023	Decompress forearm 1 space	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25024	Decompress forearm 2 spaces	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25025	Decompress forearm 2 spaces	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25028	Drainage of forearm lesion	Y	A2	$333.00	20.8706	$887.90	$471.73
25031	Drainage of forearm bursa	Y	A2	$446.00	20.8706	$887.90	$556.48
25035	Treat forearm bone lesion	Y	A2	$446.00	20.8706	$887.90	$556.48
25040	Explore/treat wrist joint	Y	A2	$717.00	25.1296	$1,069.09	$805.02
25065	Biopsy forearm soft tissues	Y	P3	.....	3.0259	$128.73	$128.73
25066	Biopsy forearm soft tissues	Y	A2	$446.00	20.0656	$853.65	$547.91
25075	Removal forearm lesion subcu	Y	A2	$446.00	15.1024	$642.50	$495.13
25076	Removal forearm lesion deep	Y	A2	$510.00	20.0656	$853.65	$595.91
25077	Remove tumor, forearm/wrist	Y	A2	$510.00	20.0656	$853.65	$595.91
25085	Incision of wrist capsule	Y	A2	$510.00	20.8706	$887.90	$604.48
25100	Biopsy of wrist joint	Y	A2	$446.00	20.8706	$887.90	$556.48
25101	Explore/treat wrist joint	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25105	Remove wrist joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25107	Remove wrist joint cartilage	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25109	Excise tendon forearm/wrist	Y	G2	.....	20.8706	$887.90	$887.90
25110	Remove wrist tendon lesion	Y	A2	$510.00	20.8706	$887.90	$604.48
25111	Remove wrist tendon lesion	Y	A2	$510.00	16.1540	$687.24	$554.31
25112	Reremove wrist tendon lesion	Y	A2	$630.00	16.1540	$687.24	$644.31
25115	Remove wrist/forearm lesion	Y	A2	$630.00	20.8706	$887.90	$694.48
25116	Remove wrist/forearm lesion	Y	A2	$630.00	20.8706	$887.90	$694.48
25118	Excise wrist tendon sheath	Y	A2	$446.00	25.1296	$1,069.09	$601.77
25119	Partial removal of ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25120	Removal of forearm lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25125	Remove/graft forearm lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25126	Remove/graft forearm lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
25130	Removal of wrist lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25135	Remove & graft wrist lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25136	Remove & graft wrist lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25145	Remove forearm bone lesion	Y	A2	$446.00	25.1296	$1,069.09	$601.77
25150	Partial removal of ulna	Y	A2	$446.00	25.1296	$1,069.09	$601.77
25151	Partial removal of radius	Y	A2	$446.00	25.1296	$1,069.09	$601.77
25210	Removal of wrist bone	Y	A2	$510.00	25.8758	$1,100.83	$657.71
25215	Removal of wrist bones	Y	A2	$630.00	25.8758	$1,100.83	$747.71
25230	Partial removal of radius	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25240	Partial removal of ulna	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25246	Injection for wrist x-ray		N1				
25248	Remove forearm foreign body	Y	A2	$446.00	20.8706	$887.90	$556.48
25250	Removal of wrist prosthesis	Y	A2	$333.00	25.1296	$1,069.09	$517.02
25251	Removal of wrist prosthesis	Y	A2	$333.00	25.1296	$1,069.09	$517.02
25259	Manipulate wrist w/anesthes	Y	G2		1.6857	$71.71	$71.71
25260	Repair forearm tendon/muscle	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25263	Repair forearm tendon/muscle	Y	A2	$446.00	25.1296	$1,069.09	$601.77
25265	Repair forearm tendon/muscle	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25270	Repair forearm tendon/muscle	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25272	Repair forearm tendon/muscle	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25274	Repair forearm tendon/muscle	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25275	Repair forearm tendon sheath	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25280	Revise wrist/forearm tendon	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25290	Incise wrist/forearm tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25295	Release wrist/forearm tendon	Y	A2	$510.00	20.8706	$887.90	$604.48
25300	Fusion of tendons at wrist	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25301	Fusion of tendons at wrist	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25310	Transplant forearm tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25312	Transplant forearm tendon	Y	A2	$630.00	41.0893	$1,748.06	$909.52
25315	Revise palsy hand tendon(s)	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25316	Revise palsy hand tendon(s)	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
25320	Repair/revise wrist joint	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25332	Revise wrist joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
25335	Realignment of hand	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25337	Reconstruct ulna/radioulnar	Y	A2	$717.00	41.0893	$1,748.06	$974.77
25350	Revision of radius	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
25355	Revision of radius	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25360	Revision of ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25365	Revise radius & ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25370	Revise radius or ulna	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25375	Revise radius & ulna	Y	A2	$630.00	41.0893	$1,748.06	$909.52
25390	Shorten radius or ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25391	Lengthen radius or ulna	Y	A2	$630.00	41.0893	$1,748.06	$909.52
25392	Shorten radius & ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25393	Lengthen radius & ulna	Y	A2	$630.00	41.0893	$1,748.06	$909.52
25394	Repair carpal bone, shorten	Y	G2		16.1540	$687.24	$687.24
25400	Repair radius or ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25405	Repair/graft radius or ulna	Y	A2	$630.00	25.1296	$1,069.09	$739.77
25415	Repair radius & ulna	Y	A2	$510.00	25.1296	$1,069.09	$649.77
25420	Repair/graft radius & ulna	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
25425	Repair/graft radius or ulna	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25426	Repair/graft radius & ulna	Y	A2	$630.00	41.0893	$1,748.06	$909.52
25430	Vasc graft into carpal bone	Y	G2		25.8758	$1,100.83	$1,100.83
25431	Repair nonunion carpal bone	Y	G2		25.8758	$1,100.83	$1,100.83
25440	Repair/graft wrist bone	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
25441	Reconstruct wrist joint	Y	A2	$717.00	107.1942	$4,560.36	$1,677.84
25442	Reconstruct wrist joint	Y	A2	$717.00	107.1942	$4,560.36	$1,677.84
25443	Reconstruct wrist joint	Y	A2	$717.00	47.4378	$2,018.15	$1,042.29
25444	Reconstruct wrist joint	Y	A2	$717.00	47.4378	$2,018.15	$1,042.29
25445	Reconstruct wrist joint	Y	A2	$717.00	47.4378	$2,018.15	$1,042.29
25446	Wrist replacement	Y	A2	$995.00	107.1942	$4,560.36	$1,886.34
25447	Repair wrist joint(s)	Y	A2	$717.00	33.4505	$1,423.08	$893.52
25449	Remove wrist joint implant	Y	A2	$717.00	33.4505	$1,423.08	$893.52

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
25450	Revision of wrist joint	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25455	Revision of wrist joint	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25490	Reinforce radius	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25491	Reinforce ulna	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25492	Reinforce radius and ulna	Y	A2	$510.00	41.0893	$1,748.06	$819.52
25500	Treat fracture of radius	Y	P2	.....	1.6857	$71.71	$71.71
25505	Treat fracture of radius	Y	A2	$103.62	1.6857	$71.71	$95.64
25515	Treat fracture of radius	Y	A2	$510.00	37.5382	$1,596.99	$781.75
25520	Treat fracture of radius	Y	A2	$103.62	1.6857	$71.71	$95.64
25525	Treat fracture of radius	Y	A2	$630.00	37.5382	$1,596.99	$871.75
25526	Treat fracture of radius	Y	A2	$717.00	37.5382	$1,596.99	$937.00
25530	Treat fracture of ulna	Y	P2	.....	1.6857	$71.71	$71.71
25535	Treat fracture of ulna	Y	A2	$103.62	1.6857	$71.71	$95.64
25545	Treat fracture of ulna	Y	A2	$510.00	37.5382	$1,596.99	$781.75
25560	Treat fracture radius & ulna	Y	P2	.....	1.6857	$71.71	$71.71
25565	Treat fracture radius & ulna	Y	A2	$103.62	1.6857	$71.71	$95.64
25574	Treat fracture radius & ulna	Y	A2	$510.00	57.2172	$2,434.19	$991.05
25575	Treat fracture radius/ulna	Y	A2	$510.00	57.2172	$2,434.19	$991.05
25600	Treat fracture radius/ulna	Y	P2	.....	1.6857	$71.71	$71.71
25605	Treat fracture radius/ulna	Y	A2	$103.62	1.6857	$71.71	$95.64
25606	Treat fx distal radial	Y	A2	$510.00	25.5264	$1,085.97	$653.99
25607	Treat fx rad extra-articul	Y	A2	$717.00	57.2172	$2,434.19	$1,146.30
25608	Treat fx rad intra-articul	Y	A2	$717.00	57.2172	$2,434.19	$1,146.30
25609	Treat fx radial 3+ frag	Y	A2	$717.00	57.2172	$2,434.19	$1,146.30
25622	Treat wrist bone fracture	Y	P2	.....	1.6857	$71.71	$71.71
25624	Treat wrist bone fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
25628	Treat wrist bone fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
25630	Treat wrist bone fracture	Y	P2	.....	1.6857	$71.71	$71.71
25635	Treat wrist bone fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
25645	Treat wrist bone fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
25650	Treat wrist bone fracture	Y	P2	.....	1.6857	$71.71	$71.71
25651	Pin ulnar styloid fracture	Y	G2	.....	25.5264	$1,085.97	$1,085.97
25652	Treat fracture ulnar styloid	Y	G2	.....	37.5382	$1,596.99	$1,596.99
25660	Treat wrist dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
25670	Treat wrist dislocation	Y	A2	$510.00	25.5264	$1,085.97	$653.99
25671	Pin radioulnar dislocation	Y	A2	$333.00	25.5264	$1,085.97	$521.24
25675	Treat wrist dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
25676	Treat wrist dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
25680	Treat wrist fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
25685	Treat wrist fracture	Y	A2	$510.00	25.5264	$1,085.97	$653.99
25690	Treat wrist dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
25695	Treat wrist dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
25800	Fusion of wrist joint	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
25805	Fusion/graft of wrist joint	Y	A2	$717.00	41.0893	$1,748.06	$974.77
25810	Fusion/graft of wrist joint	Y	A2	$717.00	66.5800	$2,832.51	$1,245.88
25820	Fusion of hand bones	Y	A2	$630.00	16.1540	$687.24	$644.31
25825	Fuse hand bones with graft	Y	A2	$717.00	25.8758	$1,100.83	$812.96
25830	Fusion, radioulnar jnt/ulna	Y	A2	$717.00	66.5800	$2,832.51	$1,245.88
25907	Amputation follow-up surgery	Y	A2	$510.00	20.8706	$887.90	$604.48
25922	Amputate hand at wrist	Y	A2	$510.00	20.8706	$887.90	$604.48
25929	Amputation follow-up surgery	Y	A2	$510.00	14.0346	$597.07	$531.77
26010	Drainage of finger abscess	Y	P2	.....	1.4392	$61.23	$61.23
26011	Drainage of finger abscess	Y	A2	$333.00	11.1535	$474.50	$368.38
26020	Drain hand tendon sheath	Y	A2	$446.00	16.1540	$687.24	$506.31
26025	Drainage of palm bursa	Y	A2	$333.00	16.1540	$687.24	$421.56
26030	Drainage of palm bursa(s)	Y	A2	$446.00	16.1540	$687.24	$506.31
26034	Treat hand bone lesion	Y	A2	$446.00	16.1540	$687.24	$506.31
26035	Decompress fingers/hand	Y	G2	.....	16.1540	$687.24	$687.24
26040	Release palm contracture	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26045	Release palm contracture	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26055	Incise finger tendon sheath	Y	A2	$446.00	16.1540	$687.24	$506.31
26060	Incision of finger tendon	Y	A2	$446.00	16.1540	$687.24	$506.31
26070	Explore/treat hand joint	Y	A2	$446.00	16.1540	$687.24	$506.31

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
26075	Explore/treat finger joint	Y	A2	$630.00	16.1540	$687.24	$644.31
26080	Explore/treat finger joint	Y	A2	$630.00	16.1540	$687.24	$644.31
26100	Biopsy hand joint lining	Y	A2	$446.00	16.1540	$687.24	$506.31
26105	Biopsy finger joint lining	Y	A2	$333.00	16.1540	$687.24	$421.56
26110	Biopsy finger joint lining	Y	A2	$333.00	16.1540	$687.24	$421.56
26115	Removal hand lesion subcut	Y	A2	$446.00	20.0656	$853.65	$547.91
26116	Removal hand lesion, deep	Y	A2	$446.00	20.0656	$853.65	$547.91
26117	Remove tumor, hand/finger	Y	A2	$510.00	20.0656	$853.65	$595.91
26121	Release palm contracture	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26123	Release palm contracture	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26125	Release palm contracture	Y	A2	$630.00	16.1540	$687.24	$644.31
26130	Remove wrist joint lining	Y	A2	$510.00	16.1540	$687.24	$554.31
26135	Revise finger joint, each	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26140	Revise finger joint, each	Y	A2	$446.00	16.1540	$687.24	$506.31
26145	Tendon excision, palm/finger	Y	A2	$510.00	16.1540	$687.24	$554.31
26160	Remove tendon sheath lesion	Y	A2	$510.00	16.1540	$687.24	$554.31
26170	Removal of palm tendon, each	Y	A2	$510.00	16.1540	$687.24	$554.31
26180	Removal of finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26185	Remove finger bone	Y	A2	$630.00	16.1540	$687.24	$644.31
26200	Remove hand bone lesion	Y	A2	$446.00	16.1540	$687.24	$506.31
26205	Remove/graft bone lesion	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26210	Removal of finger lesion	Y	A2	$446.00	16.1540	$687.24	$506.31
26215	Remove/graft finger lesion	Y	A2	$510.00	16.1540	$687.24	$554.31
26230	Partial removal of hand bone	Y	A2	$992.95	16.1540	$687.24	$916.52
26235	Partial removal, finger bone	Y	A2	$510.00	16.1540	$687.24	$554.31
26236	Partial removal, finger bone	Y	A2	$510.00	16.1540	$687.24	$554.31
26250	Extensive hand surgery	Y	A2	$510.00	16.1540	$687.24	$554.31
26255	Extensive hand surgery	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26260	Extensive finger surgery	Y	A2	$510.00	16.1540	$687.24	$554.31
26261	Extensive finger surgery	Y	A2	$510.00	16.1540	$687.24	$554.31
26262	Partial removal of finger	Y	A2	$446.00	16.1540	$687.24	$506.31
26320	Removal of implant from hand	Y	A2	$446.00	15.1024	$642.50	$495.13
26340	Manipulate finger w/anesth	Y	G2	.....	1.6857	$71.71	$71.71
26350	Repair finger/hand tendon	Y	A2	$333.00	25.8758	$1,100.83	$524.96
26352	Repair/graft hand tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26356	Repair finger/hand tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26357	Repair finger/hand tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26358	Repair/graft hand tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26370	Repair finger/hand tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26372	Repair/graft hand tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26373	Repair finger/hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26390	Revise hand/finger tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26392	Repair/graft hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26410	Repair hand tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26412	Repair/graft hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26415	Excision, hand/finger tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26416	Graft hand or finger tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26418	Repair finger tendon	Y	A2	$630.00	16.1540	$687.24	$644.31
26420	Repair/graft finger tendon	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26426	Repair finger/hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26428	Repair/graft finger tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26432	Repair finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26433	Repair finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26434	Repair/graft finger tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26437	Realignment of tendons	Y	A2	$510.00	16.1540	$687.24	$554.31
26440	Release palm/finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26442	Release palm & finger tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26445	Release hand/finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26449	Release forearm/hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26450	Incision of palm tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26455	Incision of finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26460	Incise hand/finger tendon	Y	A2	$510.00	16.1540	$687.24	$554.31
26471	Fusion of finger tendons	Y	A2	$446.00	16.1540	$687.24	$506.31

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
26474	Fusion of finger tendons	Y	A2	$446.00	16.1540	$687.24	$506.31
26476	Tendon lengthening	Y	A2	$333.00	16.1540	$687.24	$421.56
26477	Tendon shortening	Y	A2	$333.00	16.1540	$687.24	$421.56
26478	Lengthening of hand tendon	Y	A2	$333.00	16.1540	$687.24	$421.56
26479	Shortening of hand tendon	Y	A2	$333.00	16.1540	$687.24	$421.56
26480	Transplant hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26483	Transplant/graft hand tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26485	Transplant palm tendon	Y	A2	$446.00	25.8758	$1,100.83	$609.71
26489	Transplant/graft palm tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26490	Revise thumb tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26492	Tendon transfer with graft	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26494	Hand tendon/muscle transfer	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26496	Revise thumb tendon	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26497	Finger tendon transfer	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26498	Finger tendon transfer	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26499	Revision of finger	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26500	Hand tendon reconstruction	Y	A2	$630.00	16.1540	$687.24	$644.31
26502	Hand tendon reconstruction	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26508	Release thumb contracture	Y	A2	$510.00	16.1540	$687.24	$554.31
26510	Thumb tendon transfer	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26516	Fusion of knuckle joint	Y	A2	$333.00	25.8758	$1,100.83	$524.96
26517	Fusion of knuckle joints	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26518	Fusion of knuckle joints	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26520	Release knuckle contracture	Y	A2	$510.00	16.1540	$687.24	$554.31
26525	Release finger contracture	Y	A2	$510.00	16.1540	$687.24	$554.31
26530	Revise knuckle joint	Y	A2	$510.00	33.4505	$1,423.08	$738.27
26531	Revise knuckle with implant	Y	A2	$995.00	47.4378	$2,018.15	$1,250.79
26535	Revise finger joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
26536	Revise/implant finger joint	Y	A2	$717.00	47.4378	$2,018.15	$1,042.29
26540	Repair hand joint	Y	A2	$630.00	16.1540	$687.24	$644.31
26541	Repair hand joint with graft	Y	A2	$995.00	25.8758	$1,100.83	$1,021.46
26542	Repair hand joint with graft	Y	A2	$630.00	16.1540	$687.24	$644.31
26545	Reconstruct finger joint	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26546	Repair nonunion hand	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26548	Reconstruct finger joint	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26550	Construct thumb replacement	Y	A2	$446.00	25.8758	$1,100.83	$609.71
26555	Positional change of finger	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26560	Repair of web finger	Y	A2	$446.00	16.1540	$687.24	$506.31
26561	Repair of web finger	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26562	Repair of web finger	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26565	Correct metacarpal flaw	Y	A2	$717.00	25.8758	$1,100.83	$812.96
26567	Correct finger deformity	Y	A2	$717.00	25.8758	$1,100.83	$812.96
26568	Lengthen metacarpal/finger	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26580	Repair hand deformity	Y	A2	$717.00	16.1540	$687.24	$709.56
26587	Reconstruct extra finger	Y	A2	$717.00	16.1540	$687.24	$709.56
26590	Repair finger deformity	Y	A2	$717.00	16.1540	$687.24	$709.56
26591	Repair muscles of hand	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26593	Release muscles of hand	Y	A2	$510.00	16.1540	$687.24	$554.31
26596	Excision constricting tissue	Y	A2	$446.00	16.1540	$687.24	$506.31
26600	Treat metacarpal fracture	Y	P2	.....	1.6857	$71.71	$71.71
26605	Treat metacarpal fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
26607	Treat metacarpal fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
26608	Treat metacarpal fracture	Y	A2	$630.00	25.5264	$1,085.97	$743.99
26615	Treat metacarpal fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75
26641	Treat thumb dislocation	Y	G2	.....	1.6857	$71.71	$71.71
26645	Treat thumb fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
26650	Treat thumb fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
26665	Treat thumb fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75
26670	Treat hand dislocation	Y	G2	.....	1.6857	$71.71	$71.71
26675	Treat hand dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
26676	Pin hand dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
26685	Treat hand dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
26686	Treat hand dislocation	Y	A2	$510.00	57.2172	$2,434.19	$991.05

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
26700	Treat knuckle dislocation	Y	G2		1.6857	$71.71	$71.71
26705	Treat knuckle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
26706	Pin knuckle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
26715	Treat knuckle dislocation	Y	A2	$630.00	37.5382	$1,596.99	$871.75
26720	Treat finger fracture, each	Y	P2		1.6857	$71.71	$71.71
26725	Treat finger fracture, each	Y	P2		1.6857	$71.71	$71.71
26727	Treat finger fracture, each	Y	A2	$995.00	25.5264	$1,085.97	$1,017.74
26735	Treat finger fracture, each	Y	A2	$630.00	37.5382	$1,596.99	$871.75
26740	Treat finger fracture, each	Y	P2		1.6857	$71.71	$71.71
26742	Treat finger fracture, each	Y	A2	$103.62	1.6857	$71.71	$95.64
26746	Treat finger fracture, each	Y	A2	$717.00	37.5382	$1,596.99	$937.00
26750	Treat finger fracture, each	Y	P2		1.6857	$71.71	$71.71
26755	Treat finger fracture, each	Y	G2		1.6857	$71.71	$71.71
26756	Pin finger fracture, each	Y	A2	$446.00	25.5264	$1,085.97	$605.99
26765	Treat finger fracture, each	Y	A2	$630.00	37.5382	$1,596.99	$871.75
26770	Treat finger dislocation	Y	G2		1.6857	$71.71	$71.71
26775	Treat finger dislocation	Y	G2		14.5947	$620.90	$620.90
26776	Pin finger dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
26785	Treat finger dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
26820	Thumb fusion with graft	Y	A2	$717.00	25.8758	$1,100.83	$812.96
26841	Fusion of thumb	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26842	Thumb fusion with graft	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26843	Fusion of hand joint	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26844	Fusion/graft of hand joint	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26850	Fusion of knuckle	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26852	Fusion of knuckle with graft	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26860	Fusion of finger joint	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26861	Fusion of finger jnt, add-on	Y	A2	$446.00	25.8758	$1,100.83	$609.71
26862	Fusion/graft of finger joint	Y	A2	$630.00	25.8758	$1,100.83	$747.71
26863	Fuse/graft added joint	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26910	Amputate metacarpal bone	Y	A2	$510.00	25.8758	$1,100.83	$657.71
26951	Amputation of finger/thumb	Y	A2	$446.00	16.1540	$687.24	$506.31
26952	Amputation of finger/thumb	Y	A2	$630.00	16.1540	$687.24	$644.31
26990	Drainage of pelvis lesion	Y	A2	$333.00	20.8706	$887.90	$471.73
26991	Drainage of pelvis bursa	Y	A2	$333.00	20.8706	$887.90	$471.73
27000	Incision of hip tendon	Y	A2	$446.00	20.8706	$887.90	$556.48
27001	Incision of hip tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27003	Incision of hip tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27033	Exploration of hip joint	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27035	Denervation of hip joint	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27040	Biopsy of soft tissues	Y	A2	$333.00	6.8083	$289.65	$322.16
27041	Biopsy of soft tissues	Y	A2	$418.49	6.8083	$289.65	$386.28
27047	Remove hip/pelvis lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
27048	Remove hip/pelvis lesion	Y	A2	$510.00	20.0656	$853.65	$595.91
27049	Remove tumor, hip/pelvis	Y	A2	$510.00	20.0656	$853.65	$595.91
27050	Biopsy of sacroiliac joint	Y	A2	$510.00	20.8706	$887.90	$604.48
27052	Biopsy of hip joint	Y	A2	$510.00	20.8706	$887.90	$604.48
27060	Removal of ischial bursa	Y	A2	$717.00	20.8706	$887.90	$759.73
27062	Remove femur lesion/bursa	Y	A2	$717.00	20.8706	$887.90	$759.73
27065	Removal of hip bone lesion	Y	A2	$717.00	20.8706	$887.90	$759.73
27066	Removal of hip bone lesion	Y	A2	$717.00	25.1296	$1,069.09	$805.02
27067	Remove/graft hip bone lesion	Y	A2	$717.00	25.1296	$1,069.09	$805.02
27080	Removal of tail bone	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27086	Remove hip foreign body	Y	A2	$333.00	6.8083	$289.65	$322.16
27087	Remove hip foreign body	Y	A2	$510.00	20.8706	$887.90	$604.48
27093	Injection for hip x-ray		N1				
27095	Injection for hip x-ray		N1				
27097	Revision of hip tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27098	Transfer tendon to pelvis	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27100	Transfer of abdominal muscle	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27105	Transfer of spinal muscle	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27110	Transfer of iliopsoas muscle	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27111	Transfer of iliopsoas muscle	Y	A2	$630.00	41.0893	$1,748.06	$909.52

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
27193	Treat pelvic ring fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27194	Treat pelvic ring fracture	Y	A2	$446.00	14.5947	$620.90	$489.73
27200	Treat tail bone fracture	Y	P2	.....	1.6857	$71.71	$71.71
27202	Treat tail bone fracture	Y	A2	$446.00	37.5382	$1,596.99	$733.75
27220	Treat hip socket fracture	Y	G2	.....	1.6857	$71.71	$71.71
27230	Treat thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27238	Treat thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27246	Treat thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27250	Treat hip dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
27252	Treat hip dislocation	Y	A2	$446.00	14.5947	$620.90	$489.73
27256	Treat hip dislocation	Y	G2	.....	1.6857	$71.71	$71.71
27257	Treat hip dislocation	Y	A2	$510.00	14.5947	$620.90	$537.73
27265	Treat hip dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
27266	Treat hip dislocation	Y	A2	$446.00	14.5947	$620.90	$489.73
27275	Manipulation of hip joint	Y	A2	$446.00	14.5947	$620.90	$489.73
27301	Drain thigh/knee lesion	Y	A2	$510.00	17.5086	$744.87	$568.72
27305	Incise thigh tendon & fascia	Y	A2	$446.00	20.8706	$887.90	$556.48
27306	Incision of thigh tendon	Y	A2	$510.00	20.8706	$887.90	$604.48
27307	Incision of thigh tendons	Y	A2	$510.00	20.8706	$887.90	$604.48
27310	Exploration of knee joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27323	Biopsy, thigh soft tissues	Y	A2	$333.00	6.8083	$289.65	$322.16
27324	Biopsy, thigh soft tissues	Y	A2	$333.00	20.0656	$853.65	$463.16
27325	Neurectomy, hamstring	Y	A2	$446.00	17.8499	$759.39	$524.35
27326	Neurectomy, popliteal	Y	A2	$446.00	17.8499	$759.39	$524.35
27327	Removal of thigh lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
27328	Removal of thigh lesion	Y	A2	$510.00	20.0656	$853.65	$595.91
27329	Remove tumor, thigh/knee	Y	A2	$630.00	20.0656	$853.65	$685.91
27330	Biopsy, knee joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27331	Explore/treat knee joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27332	Removal of knee cartilage	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27333	Removal of knee cartilage	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27334	Remove knee joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27335	Remove knee joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27340	Removal of kneecap bursa	Y	A2	$510.00	20.8706	$887.90	$604.48
27345	Removal of knee cyst	Y	A2	$630.00	20.8706	$887.90	$694.48
27347	Remove knee cyst	Y	A2	$630.00	20.8706	$887.90	$694.48
27350	Removal of kneecap	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27355	Remove femur lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27356	Remove femur lesion/graft	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27357	Remove femur lesion/graft	Y	A2	$717.00	25.1296	$1,069.09	$805.02
27358	Remove femur lesion/fixation	Y	A2	$717.00	25.1296	$1,069.09	$805.02
27360	Partial removal, leg bone(s)	Y	A2	$717.00	25.1296	$1,069.09	$805.02
27370	Injection for knee x-ray	.....	N1	.....	.....	.....	.....
27372	Removal of foreign body	Y	A2	$995.00	20.0656	$853.65	$959.66
27380	Repair of kneecap tendon	Y	A2	$333.00	20.8706	$887.90	$471.73
27381	Repair/graft kneecap tendon	Y	A2	$510.00	20.8706	$887.90	$604.48
27385	Repair of thigh muscle	Y	A2	$510.00	20.8706	$887.90	$604.48
27386	Repair/graft of thigh muscle	Y	A2	$510.00	20.8706	$887.90	$604.48
27390	Incision of thigh tendon	Y	A2	$333.00	20.8706	$887.90	$471.73
27391	Incision of thigh tendons	Y	A2	$446.00	20.8706	$887.90	$556.48
27392	Incision of thigh tendons	Y	A2	$510.00	20.8706	$887.90	$604.48
27393	Lengthening of thigh tendon	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27394	Lengthening of thigh tendons	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27395	Lengthening of thigh tendons	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27396	Transplant of thigh tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27397	Transplants of thigh tendons	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27400	Revise thigh muscles/tendons	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27403	Repair of knee cartilage	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27405	Repair of knee ligament	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27407	Repair of knee ligament	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
27409	Repair of knee ligaments	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27418	Repair degenerated kneecap	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27420	Revision of unstable kneecap	Y	A2	$510.00	41.0893	$1,748.06	$819.52

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
27422	Revision of unstable kneecap	Y	A2	$995.00	41.0893	$1,748.06	$1,183.27
27424	Revision/removal of kneecap	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27425	Lat retinacular release open	Y	A2	$995.00	25.1296	$1,069.09	$1,013.52
27427	Reconstruction, knee	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27428	Reconstruction, knee	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
27429	Reconstruction, knee	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
27430	Revision of thigh muscles	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27435	Incision of knee joint	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27437	Revise kneecap	Y	A2	$630.00	33.4505	$1,423.08	$828.27
27438	Revise kneecap with implant	Y	A2	$717.00	47.4378	$2,018.15	$1,042.29
27440	Revision of knee joint	Y	G2	.....	33.4505	$1,423.08	$1,423.08
27441	Revision of knee joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
27442	Revision of knee joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
27443	Revision of knee joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
27446	Revision of knee joint	Y	G2	.....	205.6815	$8,750.31	$8,750.31
27496	Decompression of thigh/knee	Y	A2	$717.00	20.8706	$887.90	$759.73
27497	Decompression of thigh/knee	Y	A2	$510.00	20.8706	$887.90	$604.48
27498	Decompression of thigh/knee	Y	A2	$510.00	20.8706	$887.90	$604.48
27499	Decompression of thigh/knee	Y	A2	$510.00	20.8706	$887.90	$604.48
27500	Treatment of thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27501	Treatment of thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27502	Treatment of thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27503	Treatment of thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27508	Treatment of thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27509	Treatment of thigh fracture	Y	A2	$510.00	25.5264	$1,085.97	$653.99
27510	Treatment of thigh fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27516	Treat thigh fx growth plate	Y	A2	$103.62	1.6857	$71.71	$95.64
27517	Treat thigh fx growth plate	Y	A2	$103.62	1.6857	$71.71	$95.64
27520	Treat kneecap fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27530	Treat knee fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27532	Treat knee fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27538	Treat knee fracture(s)	Y	A2	$103.62	1.6857	$71.71	$95.64
27550	Treat knee dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
27552	Treat knee dislocation	Y	A2	$333.00	14.5947	$620.90	$404.98
27560	Treat kneecap dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
27562	Treat kneecap dislocation	Y	A2	$333.00	14.5947	$620.90	$404.98
27566	Treat kneecap dislocation	Y	A2	$446.00	37.5382	$1,596.99	$733.75
27570	Fixation of knee joint	Y	A2	$333.00	14.5947	$620.90	$404.98
27594	Amputation follow-up surgery	Y	A2	$510.00	20.8706	$887.90	$604.48
27600	Decompression of lower leg	Y	A2	$510.00	20.8706	$887.90	$604.48
27601	Decompression of lower leg	Y	A2	$510.00	20.8706	$887.90	$604.48
27602	Decompression of lower leg	Y	A2	$510.00	20.8706	$887.90	$604.48
27603	Drain lower leg lesion	Y	A2	$446.00	17.5086	$744.87	$520.72
27604	Drain lower leg bursa	Y	A2	$446.00	20.8706	$887.90	$556.48
27605	Incision of achilles tendon	Y	A2	$333.00	20.4263	$869.00	$467.00
27606	Incision of achilles tendon	Y	A2	$333.00	20.8706	$887.90	$471.73
27607	Treat lower leg bone lesion	Y	A2	$446.00	20.8706	$887.90	$556.48
27610	Explore/treat ankle joint	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27612	Exploration of ankle joint	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27613	Biopsy lower leg soft tissue	Y	P3	.....	2.8569	$121.54	$121.54
27614	Biopsy lower leg soft tissue	Y	A2	$446.00	20.0656	$853.65	$547.91
27615	Remove tumor, lower leg	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27618	Remove lower leg lesion	Y	A2	$446.00	15.1024	$642.50	$495.13
27619	Remove lower leg lesion	Y	A2	$510.00	20.0656	$853.65	$595.91
27620	Explore/treat ankle joint	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27625	Remove ankle joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27626	Remove ankle joint lining	Y	A2	$630.00	25.1296	$1,069.09	$739.77
27630	Removal of tendon lesion	Y	A2	$510.00	20.8706	$887.90	$604.48
27635	Remove lower leg bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27637	Remove/graft leg bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27638	Remove/graft leg bone lesion	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27640	Partial removal of tibia	Y	A2	$446.00	41.0893	$1,748.06	$771.52
27641	Partial removal of fibula	Y	A2	$446.00	25.1296	$1,069.09	$601.77

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
27647	Extensive ankle/heel surgery	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27648	Injection for ankle x-ray		N1				
27650	Repair achilles tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27652	Repair/graft achilles tendon	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
27654	Repair of achilles tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27656	Repair leg fascia defect	Y	A2	$446.00	20.8706	$887.90	$556.48
27658	Repair of leg tendon, each	Y	A2	$333.00	20.8706	$887.90	$471.73
27659	Repair of leg tendon, each	Y	A2	$446.00	20.8706	$887.90	$556.48
27664	Repair of leg tendon, each	Y	A2	$446.00	20.8706	$887.90	$556.48
27665	Repair of leg tendon, each	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27675	Repair lower leg tendons	Y	A2	$446.00	20.8706	$887.90	$556.48
27676	Repair lower leg tendons	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27680	Release of lower leg tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27681	Release of lower leg tendons	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27685	Revision of lower leg tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27686	Revise lower leg tendons	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27687	Revision of calf tendon	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27690	Revise lower leg tendon	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27691	Revise lower leg tendon	Y	A2	$630.00	41.0893	$1,748.06	$909.52
27692	Revise additional leg tendon	Y	A2	$510.00	41.0893	$1,748.06	$819.52
27695	Repair of ankle ligament	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27696	Repair of ankle ligaments	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27698	Repair of ankle ligament	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27700	Revision of ankle joint	Y	A2	$717.00	33.4505	$1,423.08	$893.52
27704	Removal of ankle implant	Y	A2	$446.00	20.8706	$887.90	$556.48
27705	Incision of tibia	Y	A2	$446.00	41.0893	$1,748.06	$771.52
27707	Incision of fibula	Y	A2	$446.00	20.8706	$887.90	$556.48
27709	Incision of tibia & fibula	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27730	Repair of tibia epiphysis	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27732	Repair of fibula epiphysis	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27734	Repair lower leg epiphyses	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27740	Repair of leg epiphyses	Y	A2	$446.00	25.1296	$1,069.09	$601.77
27742	Repair of leg epiphyses	Y	A2	$446.00	41.0893	$1,748.06	$771.52
27745	Reinforce tibia	Y	A2	$510.00	66.5800	$2,832.51	$1,090.63
27750	Treatment of tibia fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27752	Treatment of tibia fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27756	Treatment of tibia fracture	Y	A2	$510.00	25.5264	$1,085.97	$653.99
27758	Treatment of tibia fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75
27759	Treatment of tibia fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
27760	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27762	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27766	Treatment of ankle fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27780	Treatment of fibula fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27781	Treatment of fibula fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27784	Treatment of fibula fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27786	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27788	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27792	Treatment of ankle fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27808	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27810	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27814	Treatment of ankle fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27816	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27818	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27822	Treatment of ankle fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27823	Treatment of ankle fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
27824	Treat lower leg fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27825	Treat lower leg fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
27826	Treat lower leg fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27827	Treat lower leg fracture	Y	A2	$510.00	57.2172	$2,434.19	$991.05
27828	Treat lower leg fracture	Y	A2	$630.00	57.2172	$2,434.19	$1,081.05
27829	Treat lower leg joint	Y	A2	$446.00	37.5382	$1,596.99	$733.75
27830	Treat lower leg dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
27831	Treat lower leg dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
27832	Treat lower leg dislocation	Y	A2	$446.00	37.5382	$1,596.99	$733.75
27840	Treat ankle dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
27842	Treat ankle dislocation	Y	A2	$333.00	14.5947	$620.90	$404.98
27846	Treat ankle dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27848	Treat ankle dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
27860	Fixation of ankle joint	Y	A2	$333.00	14.5947	$620.90	$404.98
27870	Fusion of ankle joint, open	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
27871	Fusion of tibiofibular joint	Y	A2	$630.00	66.5800	$2,832.51	$1,180.63
27884	Amputation follow-up surgery	Y	A2	$510.00	20.8706	$887.90	$604.48
27889	Amputation of foot at ankle	Y	A2	$510.00	25.1296	$1,069.09	$649.77
27892	Decompression of leg	Y	A2	$510.00	20.8706	$887.90	$604.48
27893	Decompression of leg	Y	A2	$510.00	20.8706	$887.90	$604.48
27894	Decompression of leg	Y	A2	$510.00	20.8706	$887.90	$604.48
28001	Drainage of bursa of foot	Y	P3	.....	2.8327	$120.51	$120.51
28002	Treatment of foot infection	Y	A2	$510.00	20.8706	$887.90	$604.48
28003	Treatment of foot infection	Y	A2	$510.00	20.8706	$887.90	$604.48
28005	Treat foot bone lesion	Y	A2	$510.00	20.4263	$869.00	$599.75
28008	Incision of foot fascia	Y	A2	$510.00	20.4263	$869.00	$599.75
28010	Incision of toe tendon	Y	P3	.....	2.1164	$90.04	$90.04
28011	Incision of toe tendons	Y	A2	$510.00	20.4263	$869.00	$599.75
28020	Exploration of foot joint	Y	A2	$446.00	20.4263	$869.00	$551.75
28022	Exploration of foot joint	Y	A2	$446.00	20.4263	$869.00	$551.75
28024	Exploration of toe joint	Y	A2	$446.00	20.4263	$869.00	$551.75
28035	Decompression of tibia nerve	Y	A2	$630.00	17.8499	$759.39	$662.35
28043	Excision of foot lesion	Y	A2	$446.00	20.0656	$853.65	$547.91
28045	Excision of foot lesion	Y	A2	$510.00	20.4263	$869.00	$599.75
28046	Resection of tumor, foot	Y	A2	$510.00	20.4263	$869.00	$599.75
28050	Biopsy of foot joint lining	Y	A2	$446.00	20.4263	$869.00	$551.75
28052	Biopsy of foot joint lining	Y	A2	$446.00	20.4263	$869.00	$551.75
28054	Biopsy of toe joint lining	Y	A2	$446.00	20.4263	$869.00	$551.75
28055	Neurectomy, foot	Y	A2	$630.00	17.8499	$759.39	$662.35
28060	Partial removal, foot fascia	Y	A2	$446.00	20.4263	$869.00	$551.75
28062	Removal of foot fascia	Y	A2	$510.00	20.4263	$869.00	$599.75
28070	Removal of foot joint lining	Y	A2	$510.00	20.4263	$869.00	$599.75
28072	Removal of foot joint lining	Y	A2	$510.00	20.4263	$869.00	$599.75
28080	Removal of foot lesion	Y	A2	$510.00	20.4263	$869.00	$599.75
28086	Excise foot tendon sheath	Y	A2	$446.00	20.4263	$869.00	$551.75
28088	Excise foot tendon sheath	Y	A2	$446.00	20.4263	$869.00	$551.75
28090	Removal of foot lesion	Y	A2	$510.00	20.4263	$869.00	$599.75
28092	Removal of toe lesions	Y	A2	$510.00	20.4263	$869.00	$599.75
28100	Removal of ankle/heel lesion	Y	A2	$446.00	20.4263	$869.00	$551.75
28102	Remove/graft foot lesion	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28103	Remove/graft foot lesion	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28104	Removal of foot lesion	Y	A2	$446.00	20.4263	$869.00	$551.75
28106	Remove/graft foot lesion	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28107	Remove/graft foot lesion	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28108	Removal of toe lesions	Y	A2	$446.00	20.4263	$869.00	$551.75
28110	Part removal of metatarsal	Y	A2	$510.00	20.4263	$869.00	$599.75
28111	Part removal of metatarsal	Y	A2	$510.00	20.4263	$869.00	$599.75
28112	Part removal of metatarsal	Y	A2	$510.00	20.4263	$869.00	$599.75
28113	Part removal of metatarsal	Y	A2	$510.00	20.4263	$869.00	$599.75
28114	Removal of metatarsal heads	Y	A2	$510.00	20.4263	$869.00	$599.75
28116	Revision of foot	Y	A2	$510.00	20.4263	$869.00	$599.75
28118	Removal of heel bone	Y	A2	$630.00	20.4263	$869.00	$689.75
28119	Removal of heel spur	Y	A2	$630.00	20.4263	$869.00	$689.75
28120	Part removal of ankle/heel	Y	A2	$995.00	20.4263	$869.00	$963.50
28122	Partial removal of foot bone	Y	A2	$510.00	20.4263	$869.00	$599.75
28124	Partial removal of toe	Y	P3	.....	4.7639	$202.67	$202.67
28126	Partial removal of toe	Y	A2	$510.00	20.4263	$869.00	$599.75
28130	Removal of ankle bone	Y	A2	$510.00	20.4263	$869.00	$599.75
28140	Removal of metatarsal	Y	A2	$510.00	20.4263	$869.00	$599.75
28150	Removal of toe	Y	A2	$510.00	20.4263	$869.00	$599.75
28153	Partial removal of toe	Y	A2	$510.00	20.4263	$869.00	$599.75

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
28160	Partial removal of toe	Y	A2	$510.00	20.4263	$869.00	$599.75
28171	Extensive foot surgery	Y	A2	$510.00	20.4263	$869.00	$599.75
28173	Extensive foot surgery	Y	A2	$510.00	20.4263	$869.00	$599.75
28175	Extensive foot surgery	Y	A2	$510.00	20.4263	$869.00	$599.75
28190	Removal of foot foreign body	Y	P3	.....	2.9855	$127.01	$127.01
28192	Removal of foot foreign body	Y	A2	$446.00	15.1024	$642.50	$495.13
28193	Removal of foot foreign body	Y	A2	$418.49	6.8083	$289.65	$386.28
28200	Repair of foot tendon	Y	A2	$510.00	20.4263	$869.00	$599.75
28202	Repair/graft of foot tendon	Y	A2	$510.00	20.4263	$869.00	$599.75
28208	Repair of foot tendon	Y	A2	$510.00	20.4263	$869.00	$599.75
28210	Repair/graft of foot tendon	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28220	Release of foot tendon	Y	P3	.....	4.4823	$190.69	$190.69
28222	Release of foot tendons	Y	A2	$333.00	20.4263	$869.00	$467.00
28225	Release of foot tendon	Y	A2	$333.00	20.4263	$869.00	$467.00
28226	Release of foot tendons	Y	A2	$333.00	20.4263	$869.00	$467.00
28230	Incision of foot tendon(s)	Y	P3	.....	4.4341	$188.64	$188.64
28232	Incision of toe tendon	Y	P3	.....	4.2329	$180.08	$180.08
28234	Incision of foot tendon	Y	A2	$446.00	20.4263	$869.00	$551.75
28238	Revision of foot tendon	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28240	Release of big toe	Y	A2	$446.00	20.4263	$869.00	$551.75
28250	Revision of foot fascia	Y	A2	$510.00	20.4263	$869.00	$599.75
28260	Release of midfoot joint	Y	A2	$510.00	20.4263	$869.00	$599.75
28261	Revision of foot tendon	Y	A2	$510.00	20.4263	$869.00	$599.75
28262	Revision of foot and ankle	Y	A2	$630.00	20.4263	$869.00	$689.75
28264	Release of midfoot joint	Y	A2	$333.00	40.8559	$1,738.13	$684.28
28270	Release of foot contracture	Y	A2	$510.00	20.4263	$869.00	$599.75
28272	Release of toe joint, each	Y	P3	.....	4.0559	$172.55	$172.55
28280	Fusion of toes	Y	A2	$446.00	20.4263	$869.00	$551.75
28285	Repair of hammertoe	Y	A2	$510.00	20.4263	$869.00	$599.75
28286	Repair of hammertoe	Y	A2	$630.00	20.4263	$869.00	$689.75
28288	Partial removal of foot bone	Y	A2	$510.00	20.4263	$869.00	$599.75
28289	Repair hallux rigidus	Y	A2	$510.00	20.4263	$869.00	$599.75
28290	Correction of bunion	Y	A2	$446.00	28.2349	$1,201.20	$634.80
28292	Correction of bunion	Y	A2	$446.00	28.2349	$1,201.20	$634.80
28293	Correction of bunion	Y	A2	$510.00	28.2349	$1,201.20	$682.80
28294	Correction of bunion	Y	A2	$510.00	28.2349	$1,201.20	$682.80
28296	Correction of bunion	Y	A2	$510.00	28.2349	$1,201.20	$682.80
28297	Correction of bunion	Y	A2	$510.00	28.2349	$1,201.20	$682.80
28298	Correction of bunion	Y	A2	$510.00	28.2349	$1,201.20	$682.80
28299	Correction of bunion	Y	A2	$717.00	28.2349	$1,201.20	$838.05
28300	Incision of heel bone	Y	A2	$446.00	40.8559	$1,738.13	$769.03
28302	Incision of ankle bone	Y	A2	$446.00	20.4263	$869.00	$551.75
28304	Incision of midfoot bones	Y	A2	$446.00	40.8559	$1,738.13	$769.03
28305	Incise/graft midfoot bones	Y	A2	$510.00	40.8559	$1,738.13	$817.03
28306	Incision of metatarsal	Y	A2	$630.00	20.4263	$869.00	$689.75
28307	Incision of metatarsal	Y	A2	$630.00	20.4263	$869.00	$689.75
28308	Incision of metatarsal	Y	A2	$446.00	20.4263	$869.00	$551.75
28309	Incision of metatarsals	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28310	Revision of big toe	Y	A2	$510.00	20.4263	$869.00	$599.75
28312	Revision of toe	Y	A2	$510.00	20.4263	$869.00	$599.75
28313	Repair deformity of toe	Y	A2	$446.00	20.4263	$869.00	$551.75
28315	Removal of sesamoid bone	Y	A2	$630.00	20.4263	$869.00	$689.75
28320	Repair of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28322	Repair of metatarsals	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28340	Resect enlarged toe tissue	Y	A2	$630.00	20.4263	$869.00	$689.75
28341	Resect enlarged toe	Y	A2	$630.00	20.4263	$869.00	$689.75
28344	Repair extra toe(s)	Y	A2	$630.00	20.4263	$869.00	$689.75
28345	Repair webbed toe(s)	Y	A2	$630.00	20.4263	$869.00	$689.75
28400	Treatment of heel fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
28405	Treatment of heel fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
28406	Treatment of heel fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28415	Treat heel fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28420	Treat/graft heel fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
28430	Treatment of ankle fracture	Y	P2		1.6857	$71.71	$71.71
28435	Treatment of ankle fracture	Y	A2	$103.62	1.6857	$71.71	$95.64
28436	Treatment of ankle fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28445	Treat ankle fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28450	Treat midfoot fracture, each	Y	P2		1.6857	$71.71	$71.71
28455	Treat midfoot fracture, each	Y	P2		1.6857	$71.71	$71.71
28456	Treat midfoot fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28465	Treat midfoot fracture, each	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28470	Treat metatarsal fracture	Y	P2		1.6857	$71.71	$71.71
28475	Treat metatarsal fracture	Y	P2		1.6857	$71.71	$71.71
28476	Treat metatarsal fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28485	Treat metatarsal fracture	Y	A2	$630.00	37.5382	$1,596.99	$871.75
28490	Treat big toe fracture	Y	P3		1.6579	$70.53	$70.53
28495	Treat big toe fracture	Y	P2		1.6857	$71.71	$71.71
28496	Treat big toe fracture	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28505	Treat big toe fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28510	Treatment of toe fracture	Y	P3		1.2956	$55.12	$55.12
28515	Treatment of toe fracture	Y	P3		1.6658	$70.87	$70.87
28525	Treat toe fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28530	Treat sesamoid bone fracture	Y	P3		1.2392	$52.72	$52.72
28531	Treat sesamoid bone fracture	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28540	Treat foot dislocation	Y	P2		1.6857	$71.71	$71.71
28545	Treat foot dislocation	Y	A2	$333.00	25.5264	$1,085.97	$521.24
28546	Treat foot dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28555	Repair foot dislocation	Y	A2	$446.00	37.5382	$1,596.99	$733.75
28570	Treat foot dislocation	Y	P2		1.6857	$71.71	$71.71
28575	Treat foot dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
28576	Treat foot dislocation	Y	A2	$510.00	25.5264	$1,085.97	$653.99
28585	Repair foot dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28600	Treat foot dislocation	Y	P2		1.6857	$71.71	$71.71
28605	Treat foot dislocation	Y	A2	$103.62	1.6857	$71.71	$95.64
28606	Treat foot dislocation	Y	A2	$446.00	25.5264	$1,085.97	$605.99
28615	Repair foot dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28630	Treat toe dislocation	Y	G2		1.6857	$71.71	$71.71
28635	Treat toe dislocation	Y	A2	$333.00	14.5947	$620.90	$404.98
28636	Treat toe dislocation	Y	A2	$510.00	25.5264	$1,085.97	$653.99
28645	Repair toe dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28660	Treat toe dislocation	Y	G2		1.6857	$71.71	$71.71
28665	Treat toe dislocation	Y	A2	$333.00	14.5947	$620.90	$404.98
28666	Treat toe dislocation	Y	A2	$510.00	25.5264	$1,085.97	$653.99
28675	Repair of toe dislocation	Y	A2	$510.00	37.5382	$1,596.99	$781.75
28705	Fusion of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28715	Fusion of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28725	Fusion of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28730	Fusion of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28735	Fusion of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28737	Revision of foot bones	Y	A2	$717.00	40.8559	$1,738.13	$972.28
28740	Fusion of foot bones	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28750	Fusion of big toe joint	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28755	Fusion of big toe joint	Y	A2	$630.00	20.4263	$869.00	$689.75
28760	Fusion of big toe joint	Y	A2	$630.00	40.8559	$1,738.13	$907.03
28810	Amputation toe & metatarsal	Y	A2	$446.00	20.4263	$869.00	$551.75
28820	Amputation of toe	Y	A2	$446.00	20.4263	$869.00	$551.75
28825	Partial amputation of toe	Y	A2	$446.00	20.4263	$869.00	$551.75
28890	High energy eswt, plantar f	Y	G2		25.1296	$1,069.09	$1,069.09
29000	Application of body cast	N	G2		1.0607	$45.13	$45.13
29010	Application of body cast	N	P2		2.2777	$96.90	$96.90
29015	Application of body cast	N	P2		2.2777	$96.90	$96.90
29020	Application of body cast	N	G2		1.0607	$45.13	$45.13
29025	Application of body cast	N	P2		1.0607	$45.13	$45.13
29035	Application of body cast	N	G2		2.2777	$96.90	$96.90
29040	Application of body cast	N	G2		1.0607	$45.13	$45.13
29044	Application of body cast	N	P2		2.2777	$96.90	$96.90

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
29046	Application of body cast	N	G2		2.2777	$96.90	$96.90
29049	Application of figure eight	N	P3		0.9736	$41.42	$41.42
29055	Application of shoulder cast	N	P2		2.2777	$96.90	$96.90
29058	Application of shoulder cast	N	P2		1.0607	$45.13	$45.13
29065	Application of long arm cast	N	P3		1.0462	$44.51	$44.51
29075	Application of forearm cast	N	P3		0.9978	$42.45	$42.45
29085	Apply hand/wrist cast	N	P3		1.0220	$43.48	$43.48
29086	Apply finger cast	N	P3		0.8048	$34.24	$34.24
29105	Apply long arm splint	N	P3		0.9334	$39.71	$39.71
29125	Apply forearm splint	N	P3		0.7966	$33.89	$33.89
29126	Apply forearm splint	N	P3		0.8932	$38.00	$38.00
29130	Application of finger splint	N	P3		0.3622	$15.41	$15.41
29131	Application of finger splint	N	P3		0.5472	$23.28	$23.28
29200	Strapping of chest	N	P3		0.5312	$22.60	$22.60
29220	Strapping of low back	N	P3		0.5312	$22.60	$22.60
29240	Strapping of shoulder	N	P3		0.6116	$26.02	$26.02
29260	Strapping of elbow or wrist	N	P3		0.5632	$23.96	$23.96
29280	Strapping of hand or finger	N	P3		0.5874	$24.99	$24.99
29305	Application of hip cast	N	G2		2.2777	$96.90	$96.90
29325	Application of hip casts	N	G2		2.2777	$96.90	$96.90
29345	Application of long leg cast	N	P3		1.3760	$58.54	$58.54
29355	Application of long leg cast	N	P3		1.3438	$57.17	$57.17
29358	Apply long leg cast brace	N	P3		1.6496	$70.18	$70.18
29365	Application of long leg cast	N	P3		1.3036	$55.46	$55.46
29405	Apply short leg cast	N	P3		0.9736	$41.42	$41.42
29425	Apply short leg cast	N	P3		0.9898	$42.11	$42.11
29435	Apply short leg cast	N	P3		1.2392	$52.72	$52.72
29440	Addition of walker to cast	N	P3		0.5230	$22.25	$22.25
29445	Apply rigid leg cast	N	P3		1.3760	$58.54	$58.54
29450	Application of leg cast	N	P2		1.0607	$45.13	$45.13
29505	Application, long leg splint	N	G2		1.0607	$45.13	$45.13
29515	Application lower leg splint	N	G2		1.0607	$45.13	$45.13
29520	Strapping of hip	N	P3		0.6116	$26.02	$26.02
29530	Strapping of knee	N	P3		0.5714	$24.31	$24.31
29540	Strapping of ankle and/or ft	N	P3		0.3862	$16.43	$16.43
29550	Strapping of toes	N	P3		0.4024	$17.12	$17.12
29580	Application of paste boot	N	P3		0.5552	$23.62	$23.62
29590	Application of foot splint	N	P3		0.4506	$19.17	$19.17
29700	Removal/revision of cast	N	P3		0.7484	$31.84	$31.84
29705	Removal/revision of cast	N	P3		0.6438	$27.39	$27.39
29710	Removal/revision of cast	N	P3		1.1990	$51.01	$51.01
29715	Removal/revision of cast	N	P3		0.9254	$39.37	$39.37
29720	Repair of body cast	N	P3		0.9254	$39.37	$39.37
29730	Windowing of cast	N	P3		0.6276	$26.70	$26.70
29740	Wedging of cast	N	P3		0.8852	$37.66	$37.66
29750	Wedging of clubfoot cast	N	P3		0.7966	$33.89	$33.89
29800	Jaw arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29804	Jaw arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29805	Shoulder arthroscopy, dx	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29806	Shoulder arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29807	Shoulder arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29819	Shoulder arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29820	Shoulder arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29821	Shoulder arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29822	Shoulder arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29823	Shoulder arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29824	Shoulder arthroscopy/surgery	Y	A2	$717.00	28.6245	$1,217.77	$842.19
29825	Shoulder arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29826	Shoulder arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29827	Arthroscop rotator cuff repr	Y	A2	$717.00	45.5027	$1,935.82	$1,021.71
29830	Elbow arthroscopy	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29834	Elbow arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29835	Elbow arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
29836	Elbow arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29837	Elbow arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29838	Elbow arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29840	Wrist arthroscopy	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29843	Wrist arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29844	Wrist arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29845	Wrist arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29846	Wrist arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29847	Wrist arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29848	Wrist endoscopy/surgery	Y	A2	$1,339.00	28.6245	$1,217.77	$1,308.69
29850	Knee arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29851	Knee arthroscopy/surgery	Y	A2	$630.00	45.5027	$1,935.82	$956.46
29855	Tibial arthroscopy/surgery	Y	A2	$630.00	45.5027	$1,935.82	$956.46
29856	Tibial arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29860	Hip arthroscopy, dx	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29861	Hip arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29862	Hip arthroscopy/surgery	Y	A2	$1,339.00	45.5027	$1,935.82	$1,488.21
29863	Hip arthroscopy/surgery	Y	A2	$630.00	45.5027	$1,935.82	$956.46
29870	Knee arthroscopy, dx	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29871	Knee arthroscopy/drainage	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29873	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29874	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29875	Knee arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29876	Knee arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29877	Knee arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29879	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29880	Knee arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29881	Knee arthroscopy/surgery	Y	A2	$630.00	28.6245	$1,217.77	$776.94
29882	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29883	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29884	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29885	Knee arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29886	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29887	Knee arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29888	Knee arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29889	Knee arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29891	Ankle arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29892	Ankle arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29893	Scope, plantar fasciotomy	Y	A2	$1,255.56	20.4263	$869.00	$1,158.92
29894	Ankle arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29895	Ankle arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29897	Ankle arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29898	Ankle arthroscopy/surgery	Y	A2	$510.00	28.6245	$1,217.77	$686.94
29899	Ankle arthroscopy/surgery	Y	A2	$510.00	45.5027	$1,935.82	$866.46
29900	Mcp joint arthroscopy, dx	Y	A2	$510.00	16.1540	$687.24	$554.31
29901	Mcp joint arthroscopy, surg	Y	A2	$510.00	16.1540	$687.24	$554.31
29902	Mcp joint arthroscopy, surg	Y	A2	$510.00	16.1540	$687.24	$554.31
30000	Drainage of nose lesion	Y	P2	.....	2.4520	$104.32	$104.32
30020	Drainage of nose lesion	Y	P2	.....	2.4520	$104.32	$104.32
30100	Intranasal biopsy	Y	P3	.....	1.7625	$74.98	$74.98
30110	Removal of nose polyp(s)	Y	P3	.....	2.7683	$117.77	$117.77
30115	Removal of nose polyp(s)	Y	A2	$446.00	16.4266	$698.84	$509.21
30117	Removal of intranasal lesion	Y	A2	$510.00	16.4266	$698.84	$557.21
30118	Removal of intranasal lesion	Y	A2	$510.00	23.3299	$992.52	$630.63
30120	Revision of nose	Y	A2	$333.00	16.4266	$698.84	$424.46
30124	Removal of nose lesion	Y	R2	.....	7.5511	$321.25	$321.25
30125	Removal of nose lesion	Y	A2	$446.00	38.1991	$1,625.10	$740.78
30130	Excise inferior turbinate	Y	A2	$510.00	16.4266	$698.84	$557.21
30140	Resect inferior turbinate	Y	A2	$446.00	23.3299	$992.52	$582.63
30150	Partial removal of nose	Y	A2	$510.00	38.1991	$1,625.10	$788.78
30160	Removal of nose	Y	A2	$630.00	38.1991	$1,625.10	$878.78
30200	Injection treatment of nose	Y	P3	.....	1.4082	$59.91	$59.91
30210	Nasal sinus therapy	Y	P3	.....	1.7784	$75.66	$75.66

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
30220	Insert nasal septal button	Y	A2	$464.15	7.5511	$321.25	$428.43
30300	Remove nasal foreign body	N	P2		0.6102	$25.96	$25.96
30310	Remove nasal foreign body	Y	A2	$333.00	16.4266	$698.84	$424.46
30320	Remove nasal foreign body	Y	A2	$446.00	16.4266	$698.84	$509.21
30400	Reconstruction of nose	Y	A2	$630.00	38.1991	$1,625.10	$878.78
30410	Reconstruction of nose	Y	A2	$717.00	38.1991	$1,625.10	$944.03
30420	Reconstruction of nose	Y	A2	$717.00	38.1991	$1,625.10	$944.03
30430	Revision of nose	Y	A2	$510.00	23.3299	$992.52	$630.63
30435	Revision of nose	Y	A2	$717.00	38.1991	$1,625.10	$944.03
30450	Revision of nose	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
30460	Revision of nose	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
30462	Revision of nose	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
30465	Repair nasal stenosis	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
30520	Repair of nasal septum	Y	A2	$630.00	23.3299	$992.52	$720.63
30540	Repair nasal defect	Y	A2	$717.00	38.1991	$1,625.10	$944.03
30545	Repair nasal defect	Y	A2	$717.00	38.1991	$1,625.10	$944.03
30560	Release of nasal adhesions	Y	A2	$150.72	2.4520	$104.32	$139.12
30580	Repair upper jaw fistula	Y	A2	$630.00	38.1991	$1,625.10	$878.78
30600	Repair mouth/nose fistula	Y	A2	$630.00	38.1991	$1,625.10	$878.78
30620	Intranasal reconstruction	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
30630	Repair nasal septum defect	Y	A2	$995.00	23.3299	$992.52	$994.38
30801	Ablate inf turbinate, superf	Y	A2	$333.00	7.5511	$321.25	$330.06
30802	Cauterization, inner nose	Y	A2	$333.00	7.5511	$321.25	$330.06
30901	Control of nosebleed	Y	P3		1.0300	$43.82	$43.82
30903	Control of nosebleed	Y	A2	$72.48	1.1791	$50.16	$66.90
30905	Control of nosebleed	Y	A2	$72.48	1.1791	$50.16	$66.90
30906	Repeat control of nosebleed	Y	A2	$72.48	1.1791	$50.16	$66.90
30915	Ligation, nasal sinus artery	Y	A2	$446.00	24.8809	$1,058.51	$599.13
30920	Ligation, upper jaw artery	Y	A2	$510.00	24.8809	$1,058.51	$647.13
30930	Ther fx, nasal inf turbinate	Y	A2	$630.00	16.4266	$698.84	$647.21
31000	Irrigation, maxillary sinus	Y	P3		2.3499	$99.97	$99.97
31002	Irrigation, sphenoid sinus	Y	R2		7.5511	$321.25	$321.25
31020	Exploration, maxillary sinus	Y	A2	$446.00	23.3299	$992.52	$582.63
31030	Exploration, maxillary sinus	Y	A2	$510.00	38.1991	$1,625.10	$788.78
31032	Explore sinus, remove polyps	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31040	Exploration behind upper jaw	Y	R2		23.3299	$992.52	$992.52
31050	Exploration, sphenoid sinus	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31051	Sphenoid sinus surgery	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31070	Exploration of frontal sinus	Y	A2	$446.00	23.3299	$992.52	$582.63
31075	Exploration of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31080	Removal of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31081	Removal of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31084	Removal of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31085	Removal of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31086	Removal of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31087	Removal of frontal sinus	Y	A2	$630.00	38.1991	$1,625.10	$878.78
31090	Exploration of sinuses	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31200	Removal of ethmoid sinus	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31201	Removal of ethmoid sinus	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31205	Removal of ethmoid sinus	Y	A2	$510.00	38.1991	$1,625.10	$788.78
31231	Nasal endoscopy, dx	Y	P2		1.4054	$59.79	$59.79
31233	Nasal/sinus endoscopy, dx	Y	A2	$86.39	1.4054	$59.79	$79.74
31235	Nasal/sinus endoscopy, dx	Y	A2	$333.00	14.7928	$629.33	$407.08
31237	Nasal/sinus endoscopy, surg	Y	A2	$446.00	14.7928	$629.33	$491.83
31238	Nasal/sinus endoscopy, surg	Y	A2	$333.00	14.7928	$629.33	$407.08
31239	Nasal/sinus endoscopy, surg	Y	A2	$630.00	21.9512	$933.87	$705.97
31240	Nasal/sinus endoscopy, surg	Y	A2	$446.00	14.7928	$629.33	$491.83
31254	Revision of ethmoid sinus	Y	A2	$510.00	21.9512	$933.87	$615.97
31255	Removal of ethmoid sinus	Y	A2	$717.00	21.9512	$933.87	$771.22
31256	Exploration maxillary sinus	Y	A2	$510.00	21.9512	$933.87	$615.97
31267	Endoscopy, maxillary sinus	Y	A2	$510.00	21.9512	$933.87	$615.97
31276	Sinus endoscopy, surgical	Y	A2	$510.00	21.9512	$933.87	$615.97
31287	Nasal/sinus endoscopy, surg	Y	A2	$510.00	21.9512	$933.87	$615.97

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
31288	Nasal/sinus endoscopy, surg	Y	A2	$510.00	21.9512	$933.87	$615.97
31300	Removal of larynx lesion	Y	A2	$717.00	23.3299	$992.52	$785.88
31320	Diagnostic incision, larynx	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31400	Revision of larynx	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31420	Removal of epiglottis	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31500	Insert emergency airway	N	G2	.....	2.4233	$103.09	$103.09
31502	Change of windpipe airway	Y	G2	.....	2.3587	$100.35	$100.35
31505	Diagnostic laryngoscopy	Y	P2	.....	0.7698	$32.75	$32.75
31510	Laryngoscopy with biopsy	Y	A2	$446.00	14.7928	$629.33	$491.83
31511	Remove foreign body, larynx	Y	A2	$86.39	1.4054	$59.79	$79.74
31512	Removal of larynx lesion	Y	A2	$446.00	14.7928	$629.33	$491.83
31513	Injection into vocal cord	Y	A2	$86.39	1.4054	$59.79	$79.74
31515	Laryngoscopy for aspiration	Y	A2	$333.00	14.7928	$629.33	$407.08
31520	Dx laryngoscopy, newborn	Y	G2	.....	1.4054	$59.79	$59.79
31525	Dx laryngoscopy excl nb	Y	A2	$333.00	14.7928	$629.33	$407.08
31526	Dx laryngoscopy w/oper scope	Y	A2	$446.00	21.9512	$933.87	$567.97
31527	Laryngoscopy for treatment	Y	A2	$333.00	21.9512	$933.87	$483.22
31528	Laryngoscopy and dilation	Y	A2	$446.00	14.7928	$629.33	$491.83
31529	Laryngoscopy and dilation	Y	A2	$446.00	14.7928	$629.33	$491.83
31530	Laryngoscopy w/fb removal	Y	A2	$446.00	21.9512	$933.87	$567.97
31531	Laryngoscopy w/fb & op scope	Y	A2	$510.00	21.9512	$933.87	$615.97
31535	Laryngoscopy w/biopsy	Y	A2	$446.00	21.9512	$933.87	$567.97
31536	Laryngoscopy w/bx & op scope	Y	A2	$510.00	21.9512	$933.87	$615.97
31540	Laryngoscopy w/exc of tumor	Y	A2	$510.00	21.9512	$933.87	$615.97
31541	Larynscop w/tumr exc + scope	Y	A2	$630.00	21.9512	$933.87	$705.97
31545	Remove vc lesion w/scope	Y	A2	$630.00	21.9512	$933.87	$705.97
31546	Remove vc lesion scope/graft	Y	A2	$630.00	21.9512	$933.87	$705.97
31560	Laryngoscop w/arytenoidectom	Y	A2	$717.00	21.9512	$933.87	$771.22
31561	Larynscop, remve cart + scop	Y	A2	$717.00	21.9512	$933.87	$771.22
31570	Laryngoscope w/vc inj	Y	A2	$446.00	14.7928	$629.33	$491.83
31571	Laryngoscop w/vc inj + scope	Y	A2	$446.00	21.9512	$933.87	$567.97
31575	Diagnostic laryngoscopy	Y	P3	.....	1.4002	$59.57	$59.57
31576	Laryngoscopy with biopsy	Y	A2	$446.00	21.9512	$933.87	$567.97
31577	Remove foreign body, larynx	Y	A2	$236.42	3.8463	$163.63	$218.22
31578	Removal of larynx lesion	Y	A2	$446.00	21.9512	$933.87	$567.97
31579	Diagnostic laryngoscopy	Y	P3	.....	2.5833	$109.90	$109.90
31580	Revision of larynx	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31582	Revision of larynx	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31588	Revision of larynx	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31590	Reinnervate larynx	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31595	Larynx nerve surgery	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31603	Incision of windpipe	Y	A2	$333.00	7.5511	$321.25	$330.06
31605	Incision of windpipe	Y	G2	.....	7.5511	$321.25	$321.25
31611	Surgery/speech prosthesis	Y	A2	$510.00	23.3299	$992.52	$630.63
31612	Puncture/clear windpipe	Y	A2	$333.00	23.3299	$992.52	$497.88
31613	Repair windpipe opening	Y	A2	$446.00	23.3299	$992.52	$582.63
31614	Repair windpipe opening	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31615	Visualization of windpipe	Y	A2	$333.00	9.5228	$405.13	$351.03
31620	Endobronchial us add-on	N	A2	$333.00	32.2854	$1,373.52	$593.13
31622	Dx bronchoscope/wash	Y	A2	$333.00	9.5228	$405.13	$351.03
31623	Dx bronchoscope/brush	Y	A2	$446.00	9.5228	$405.13	$435.78
31624	Dx bronchoscope/lavage	Y	A2	$446.00	9.5228	$405.13	$435.78
31625	Bronchoscopy w/biopsy(s)	Y	A2	$446.00	9.5228	$405.13	$435.78
31628	Bronchoscopy/lung bx, each	Y	A2	$446.00	9.5228	$405.13	$435.78
31629	Bronchoscopy/needle bx, each	Y	A2	$446.00	9.5228	$405.13	$435.78
31630	Bronchoscopy dilate/fx repr	Y	A2	$446.00	22.0099	$936.37	$568.59
31631	Bronchoscopy, dilate w/stent	Y	A2	$446.00	22.0099	$936.37	$568.59
31632	Bronchoscopy/lung bx, add'l	Y	G2	.....	9.5228	$405.13	$405.13
31633	Bronchoscopy/needle bx add'l	Y	G2	.....	9.5228	$405.13	$405.13
31635	Bronchoscopy w/fb removal	Y	A2	$446.00	9.5228	$405.13	$435.78
31636	Bronchoscopy, bronch stents	Y	A2	$446.00	22.0099	$936.37	$568.59
31637	Bronchoscopy, stent add-on	Y	A2	$333.00	9.5228	$405.13	$351.03
31638	Bronchoscopy, revise stent	Y	A2	$446.00	22.0099	$936.37	$568.59

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
31640	Bronchoscopy w/tumor excise	Y	A2	$446.00	22.0099	$936.37	$568.59
31641	Bronchoscopy, treat blockage	Y	A2	$446.00	22.0099	$936.37	$568.59
31643	Diag bronchoscope/catheter	Y	A2	$446.00	9.5228	$405.13	$435.78
31645	Bronchoscopy, clear airways	Y	A2	$333.00	9.5228	$405.13	$351.03
31646	Bronchoscopy, reclear airway	Y	A2	$333.00	9.5228	$405.13	$351.03
31656	Bronchoscopy, inj for x-ray	Y	A2	$333.00	9.5228	$405.13	$351.03
31715	Injection for bronchus x-ray		N1				
31717	Bronchial brush biopsy	Y	A2	$236.42	3.8463	$163.63	$218.22
31720	Clearance of airways	Y	A2	$47.32	0.7698	$32.75	$43.68
31730	Intro, windpipe wire/tube	Y	A2	$236.42	3.8463	$163.63	$218.22
31750	Repair of windpipe	Y	A2	$717.00	38.1991	$1,625.10	$944.03
31755	Repair of windpipe	Y	A2	$446.00	38.1991	$1,625.10	$740.78
31820	Closure of windpipe lesion	Y	A2	$333.00	16.4266	$698.84	$424.46
31825	Repair of windpipe defect	Y	A2	$446.00	23.3299	$992.52	$582.63
31830	Revise windpipe scar	Y	A2	$446.00	23.3299	$992.52	$582.63
32000	Drainage of chest	Y	A2	$222.78	3.6244	$154.19	$205.63
32002	Treatment of collapsed lung	Y	G2		3.6244	$154.19	$154.19
32019	Insert pleural catheter	Y	G2		29.5416	$1,256.79	$1,256.79
32400	Needle biopsy chest lining	Y	A2	$333.00	6.1384	$261.15	$315.04
32405	Biopsy, lung or mediastinum	Y	A2	$333.00	6.1384	$261.15	$315.04
32420	Puncture/clear lung	Y	A2	$222.78	3.6244	$154.19	$205.63
32960	Therapeutic pneumothorax	Y	G2		3.6244	$154.19	$154.19
33010	Drainage of heart sac	Y	A2	$222.78	3.6244	$154.19	$205.63
33011	Repeat drainage of heart sac	Y	A2	$222.78	3.6244	$154.19	$205.63
33206	Insertion of heart pacemaker	Y	J8		170.6370	$7,259.41	$7,259.41
33207	Insertion of heart pacemaker	Y	J8		170.6370	$7,259.41	$7,259.41
33208	Insertion of heart pacemaker	Y	J8		210.2184	$8,943.32	$8,943.32
33210	Insertion of heart electrode	Y	G2		58.8594	$2,504.06	$2,504.06
33211	Insertion of heart electrode	Y	G2		58.8594	$2,504.06	$2,504.06
33212	Insertion of pulse generator	Y	H8	$510.00	134.4886	$5,721.55	$5,311.76
33213	Insertion of pulse generator	Y	H8	$510.00	155.7342	$6,625.40	$6,192.90
33214	Upgrade of pacemaker system	Y	J8		210.2184	$8,943.32	$8,943.32
33215	Reposition pacing-defib lead	Y	G2		25.6142	$1,089.70	$1,089.70
33216	Insert lead pace-defib, one	Y	G2		58.8594	$2,504.06	$2,504.06
33217	Insert lead pace-defib, dual	Y	G2		58.8594	$2,504.06	$2,504.06
33218	Repair lead pace-defib, one	Y	G2		25.6142	$1,089.70	$1,089.70
33220	Repair lead pace-defib, dual	Y	G2		25.6142	$1,089.70	$1,089.70
33222	Revise pocket, pacemaker	Y	A2	$446.00	21.4302	$911.71	$562.43
33223	Revise pocket, pacing-defib	Y	A2	$446.00	21.4302	$911.71	$562.43
33224	Insert pacing lead & connect	Y	J8		439.4366	$18,694.95	$18,694.95
33225	Lventric pacing lead add-on	Y	J8		439.4366	$18,694.95	$18,694.95
33226	Reposition 1 ventric lead	Y	G2		25.6142	$1,089.70	$1,089.70
33233	Removal of pacemaker system	Y	A2	$446.00	25.6142	$1,089.70	$606.93
33234	Removal of pacemaker system	Y	G2		25.6142	$1,089.70	$1,089.70
33235	Removal pacemaker electrode	Y	G2		25.6142	$1,089.70	$1,089.70
33241	Remove pulse generator	Y	G2		25.6142	$1,089.70	$1,089.70
33282	Implant pat-active ht record	N	J8		99.9215	$4,250.96	$4,250.96
33284	Remove pat-active ht record	Y	G2		10.9918	$467.62	$467.62
33508	Endoscopic vein harvest		N1				
35188	Repair blood vessel lesion	Y	A2	$630.00	37.7391	$1,605.53	$873.88
35207	Repair blood vessel lesion	Y	A2	$630.00	37.7391	$1,605.53	$873.88
35473	Repair arterial blockage	Y	G2		42.9360	$1,826.63	$1,826.63
35474	Repair arterial blockage	Y	G2		42.9360	$1,826.63	$1,826.63
35476	Repair venous blockage	Y	G2		42.9360	$1,826.63	$1,826.63
35492	Atherectomy, percutaneous	Y	G2		42.9360	$1,826.63	$1,826.63
35572	Harvest femoropopliteal vein		N1				
35761	Exploration of artery/vein	Y	G2		29.2133	$1,242.82	$1,242.82
35875	Removal of clot in graft	Y	A2	$1,339.00	37.7391	$1,605.53	$1,405.63
35876	Removal of clot in graft	Y	A2	$1,339.00	37.7391	$1,605.53	$1,405.63
36000	Place needle in vein		N1				
36002	Pseudoaneurysm injection trt	N	G2		2.4606	$104.68	$104.68
36005	Injection ext venography		N1				
36010	Place catheter in vein		N1				

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
36011	Place catheter in vein		N1				
36012	Place catheter in vein		N1				
36013	Place catheter in artery		N1				
36014	Place catheter in artery		N1				
36015	Place catheter in artery		N1				
36100	Establish access to artery		N1				
36120	Establish access to artery		N1				
36140	Establish access to artery		N1				
36145	Artery to vein shunt		N1				
36160	Establish access to aorta		N1				
36200	Place catheter in aorta		N1				
36215	Place catheter in artery		N1				
36216	Place catheter in artery		N1				
36217	Place catheter in artery		N1				
36218	Place catheter in artery		N1				
36245	Place catheter in artery		N1				
36246	Place catheter in artery		N1				
36247	Place catheter in artery		N1				
36248	Place catheter in artery		N1				
36260	Insertion of infusion pump	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36261	Revision of infusion pump	Y	A2	$446.00	28.5032	$1,212.61	$637.65
36262	Removal of infusion pump	Y	A2	$333.00	22.6665	$964.30	$490.83
36400	Bl draw <3 yrs fem/jugular		N1				
36405	Bl draw <3 yrs scalp vein		N1				
36406	Bl draw <3 yrs other vein		N1				
36410	Non-routine bl draw >3 yrs		N1				
36416	Capillary blood draw		N1				
36420	Vein access cutdown <1 yr	Y	G2		0.1999	$8.50	$8.50
36425	Vein access cutdown >1 yr	Y	R2		0.1999	$8.50	$8.50
36430	Blood transfusion service	N	P3		0.7806	$33.21	$33.21
36440	Bl push transfuse, 2 yr or <	N	R2		3.4584	$147.13	$147.13
36450	Bl exchange/transfuse, nb	N	R2		3.4584	$147.13	$147.13
36468	Injection(s), spider veins	Y	R2		1.0798	$45.94	$45.94
36469	Injection(s), spider veins	Y	G2		1.0798	$45.94	$45.94
36470	Injection therapy of vein	Y	P2		1.0798	$45.94	$45.94
36471	Injection therapy of veins	Y	P2		1.0798	$45.94	$45.94
36475	Endovenous rf, 1st vein	Y	A2	$1,339.00	34.7288	$1,477.47	$1,373.62
36476	Endovenous rf, vein add-on	Y	A2	$1,339.00	34.7288	$1,477.47	$1,373.62
36478	Endovenous laser, 1st vein	Y	A2	$1,339.00	24.8809	$1,058.51	$1,268.88
36479	Endovenous laser vein addon	Y	A2	$1,339.00	24.8809	$1,058.51	$1,268.88
36481	Insertion of catheter, vein		N1				
36500	Insertion of catheter, vein		N1				
36510	Insertion of catheter, vein		N1				
36511	Apheresis wbc	N	G2		11.7134	$498.32	$498.32
36512	Apheresis rbc	N	G2		11.7134	$498.32	$498.32
36513	Apheresis platelets	N	G2		11.7134	$498.32	$498.32
36514	Apheresis plasma	N	G2		11.7134	$498.32	$498.32
36515	Apheresis, adsorp/reinfuse	N	G2		30.2231	$1,285.78	$1,285.78
36516	Apheresis, selective	N	G2		30.2231	$1,285.78	$1,285.78
36522	Photopheresis	N	G2		30.2231	$1,285.78	$1,285.78
36540	Collect blood venous device		N1				
36550	Declot vascular device	Y	P3		0.2816	$11.98	$11.98
36555	Insert non-tunnel cv cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36556	Insert non-tunnel cv cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36557	Insert tunneled cv cath	Y	A2	$446.00	22.6665	$964.30	$575.58
36558	Insert tunneled cv cath	Y	A2	$446.00	22.6665	$964.30	$575.58
36560	Insert tunneled cv cath	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36561	Insert tunneled cv cath	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36563	Insert tunneled cv cath	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36565	Insert tunneled cv cath	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36566	Insert tunneled cv cath	Y	H8	$510.00	107.1217	$4,557.28	$3,809.60
36568	Insert picc cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36569	Insert picc cath	Y	A2	$333.00	8.7846	$373.72	$343.18

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
36570	Insert picvad cath	Y	A2	$510.00	22.6665	$964.30	$623.58
36571	Insert picvad cath	Y	A2	$510.00	22.6665	$964.30	$623.58
36575	Repair tunneled cv cath	Y	A2	$446.00	8.7846	$373.72	$427.93
36576	Repair tunneled cv cath	Y	A2	$446.00	8.7846	$373.72	$427.93
36578	Replace tunneled cv cath	Y	A2	$446.00	22.6665	$964.30	$575.58
36580	Replace cvad cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36581	Replace tunneled cv cath	Y	A2	$446.00	22.6665	$964.30	$575.58
36582	Replace tunneled cv cath	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36583	Replace tunneled cv cath	Y	A2	$510.00	28.5032	$1,212.61	$685.65
36584	Replace picc cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36585	Replace picvad cath	Y	A2	$510.00	22.6665	$964.30	$623.58
36589	Removal tunneled cv cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36590	Removal tunneled cv cath	Y	A2	$333.00	8.7846	$373.72	$343.18
36595	Mech remov tunneled cv cath	Y	G2	.....	22.6665	$964.30	$964.30
36596	Mech remov tunneled cv cath	Y	G2	.....	8.7846	$373.72	$373.72
36597	Reposition venous catheter	Y	G2	.....	8.7846	$373.72	$373.72
36598*	Inj w/fluor, eval cv device	N	P2	.....	0.6102	$25.96	$25.96
36600	Withdrawal of arterial blood	.....	N1	.....	.....	.....	.....
36620	Insertion catheter, artery	.....	N1	.....	.....	.....	.....
36625	Insertion catheter, artery	.....	N1	.....	.....	.....	.....
36640	Insertion catheter, artery	Y	A2	$333.00	28.5032	$1,212.61	$552.90
36680	Insert needle, bone cavity	Y	G2	.....	1.0995	$46.78	$46.78
36800	Insertion of cannula	Y	A2	$510.00	29.2133	$1,242.82	$693.21
36810	Insertion of cannula	Y	A2	$510.00	29.2133	$1,242.82	$693.21
36815	Insertion of cannula	Y	A2	$510.00	29.2133	$1,242.82	$693.21
36818	Av fuse, uppr arm, cephalic	Y	A2	$510.00	37.7391	$1,605.53	$783.88
36819	Av fuse, uppr arm, basilic	Y	A2	$510.00	37.7391	$1,605.53	$783.88
36820	Av fusion/forearm vein	Y	A2	$510.00	37.7391	$1,605.53	$783.88
36821	Av fusion direct any site	Y	A2	$510.00	37.7391	$1,605.53	$783.88
36825	Artery-vein autograft	Y	A2	$630.00	37.7391	$1,605.53	$873.88
36830	Artery-vein nonautograft	Y	A2	$630.00	37.7391	$1,605.53	$873.88
36831	Open thrombect av fistula	Y	A2	$1,339.00	37.7391	$1,605.53	$1,405.63
36832	Av fistula revision, open	Y	A2	$630.00	37.7391	$1,605.53	$873.88
36833	Av fistula revision	Y	A2	$630.00	37.7391	$1,605.53	$873.88
36834	Repair A-V aneurysm	Y	A2	$510.00	37.7391	$1,605.53	$783.88
36835	Artery to vein shunt	Y	A2	$630.00	29.2133	$1,242.82	$783.21
36860	External cannula declotting	Y	A2	$127.40	2.0726	$88.17	$117.59
36861	Cannula declotting	Y	A2	$510.00	29.2133	$1,242.82	$693.21
36870	Percut thrombect av fistula	Y	A2	$1,339.00	32.3818	$1,377.62	$1,348.66
37184	Prim art mech thrombectomy	Y	G2	.....	37.7391	$1,605.53	$1,605.53
37185	Prim art m-thrombect add-on	Y	G2	.....	37.7391	$1,605.53	$1,605.53
37186	Sec art m-thrombect add-on	Y	G2	.....	37.7391	$1,605.53	$1,605.53
37187	Venous mech thrombectomy	Y	G2	.....	37.7391	$1,605.53	$1,605.53
37188	Venous m-thrombectomy add-on	Y	G2	.....	37.7391	$1,605.53	$1,605.53
37200	Transcatheter biopsy	Y	G2	.....	6.1384	$261.15	$261.15
37203	Transcatheter retrieval	Y	G2	.....	16.2375	$690.79	$690.79
37250	Iv us first vessel add-on	N	G2	.....	32.5472	$1,384.66	$1,384.66
37251	Iv us each add vessel add-on	N	G2	.....	32.5472	$1,384.66	$1,384.66
37500	Endoscopy ligate perf veins	Y	A2	$510.00	34.7288	$1,477.47	$751.87
37607	Ligation of a-v fistula	Y	A2	$510.00	24.8809	$1,058.51	$647.13
37609	Temporal artery procedure	Y	A2	$446.00	15.1024	$642.50	$495.13
37650	Revision of major vein	Y	A2	$446.00	24.8809	$1,058.51	$599.13
37700	Revise leg vein	Y	A2	$446.00	34.7288	$1,477.47	$703.87
37718	Ligate/strip short leg vein	Y	A2	$510.00	34.7288	$1,477.47	$751.87
37722	Ligate/strip long leg vein	Y	A2	$510.00	34.7288	$1,477.47	$751.87
37735	Removal of leg veins/lesion	Y	A2	$510.00	34.7288	$1,477.47	$751.87
37760	Ligation, leg veins, open	Y	A2	$510.00	24.8809	$1,058.51	$647.13
37765	Phleb veins - extrem - to 20	Y	R2	.....	24.8809	$1,058.51	$1,058.51
37766	Phleb veins - extrem 20+	Y	R2	.....	24.8809	$1,058.51	$1,058.51
37780	Revision of leg vein	Y	A2	$510.00	24.8809	$1,058.51	$647.13
37785	Ligate/divide/excise vein	Y	A2	$510.00	24.8809	$1,058.51	$647.13
37790	Penile venous occlusion	Y	A2	$510.00	32.9873	$1,403.38	$733.35
38200	Injection for spleen x-ray	.....	N1	.....	.....	.....	.....

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
38204	Bl donor search management		N1				
38205	Harvest allogenic stem cells	N	G2		11.7134	$498.32	$498.32
38206	Harvest auto stem cells	N	G2		11.7134	$498.32	$498.32
38220	Bone marrow aspiration	Y	P2		2.4011	$102.15	$102.15
38221	Bone marrow biopsy	Y	P2		2.4011	$102.15	$102.15
38230	Bone marrow collection	N	G2		20.3582	$866.10	$866.10
38241	Bone marrow/stem transplant	N	G2		20.3582	$866.10	$866.10
38242	Lymphocyte infuse transplant	N	R2		11.7134	$498.32	$498.32
38300	Drainage, lymph node lesion	Y	A2	$333.00	11.1535	$474.50	$368.38
38305	Drainage, lymph node lesion	Y	A2	$446.00	17.5086	$744.87	$520.72
38308	Incision of lymph channels	Y	A2	$446.00	21.2621	$904.55	$560.64
38500	Biopsy/removal, lymph nodes	Y	A2	$446.00	21.2621	$904.55	$560.64
38505	Needle biopsy, lymph nodes	Y	A2	$240.00	3.9045	$166.11	$221.53
38510	Biopsy/removal, lymph nodes	Y	A2	$446.00	21.2621	$904.55	$560.64
38520	Biopsy/removal, lymph nodes	Y	A2	$446.00	21.2621	$904.55	$560.64
38525	Biopsy/removal, lymph nodes	Y	A2	$446.00	21.2621	$904.55	$560.64
38530	Biopsy/removal, lymph nodes	Y	A2	$446.00	21.2621	$904.55	$560.64
38542	Explore deep node(s), neck	Y	A2	$446.00	37.7224	$1,604.82	$735.71
38550	Removal, neck/armpit lesion	Y	A2	$510.00	21.2621	$904.55	$608.64
38555	Removal, neck/armpit lesion	Y	A2	$630.00	21.2621	$904.55	$698.64
38570	Laparoscopy, lymph node biop	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
38571	Laparoscopy, lymphadenectomy	Y	A2	$1,339.00	70.5066	$2,999.56	$1,754.14
38572	Laparoscopy, lymphadenectomy	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
38700	Removal of lymph nodes, neck	Y	G2		21.2621	$904.55	$904.55
38740	Remove armpit lymph nodes	Y	A2	$446.00	37.7224	$1,604.82	$735.71
38745	Remove armpit lymph nodes	Y	A2	$630.00	37.7224	$1,604.82	$873.71
38760	Remove groin lymph nodes	Y	A2	$446.00	21.2621	$904.55	$560.64
38790	Inject for lymphatic x-ray		N1				
38792	Identify sentinel node		N1				
38794	Access thoracic lymph duct		N1				
40490	Biopsy of lip	Y	P3		1.4968	$63.68	$63.68
40500	Partial excision of lip	Y	A2	$446.00	16.4266	$698.84	$509.21
40510	Partial excision of lip	Y	A2	$446.00	23.3299	$992.52	$582.63
40520	Partial excision of lip	Y	A2	$446.00	16.4266	$698.84	$509.21
40525	Reconstruct lip with flap	Y	A2	$446.00	23.3299	$992.52	$582.63
40527	Reconstruct lip with flap	Y	A2	$446.00	23.3299	$992.52	$582.63
40530	Partial removal of lip	Y	A2	$446.00	23.3299	$992.52	$582.63
40650	Repair lip	Y	A2	$464.15	7.5511	$321.25	$428.43
40652	Repair lip	Y	A2	$464.15	7.5511	$321.25	$428.43
40654	Repair lip	Y	A2	$464.15	7.5511	$321.25	$428.43
40700	Repair cleft lip/nasal	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
40701	Repair cleft lip/nasal	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
40702	Repair cleft lip/nasal	Y	R2		38.1991	$1,625.10	$1,625.10
40720	Repair cleft lip/nasal	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
40761	Repair cleft lip/nasal	Y	A2	$510.00	38.1991	$1,625.10	$788.78
40800	Drainage of mouth lesion	Y	P2		1.4392	$61.23	$61.23
40801	Drainage of mouth lesion	Y	A2	$446.00	7.5511	$321.25	$414.81
40804	Removal, foreign body, mouth	N	P2		0.6102	$25.96	$25.96
40805	Removal, foreign body, mouth	Y	P3		3.8385	$163.30	$163.30
40806	Incision of lip fold	Y	P3		1.6898	$71.89	$71.89
40808	Biopsy of mouth lesion	Y	P2		2.4520	$104.32	$104.32
40810	Excision of mouth lesion	Y	P3		2.5913	$110.24	$110.24
40812	Excise/repair mouth lesion	Y	P3		3.3155	$141.05	$141.05
40814	Excise/repair mouth lesion	Y	A2	$446.00	16.4266	$698.84	$509.21
40816	Excision of mouth lesion	Y	A2	$446.00	23.3299	$992.52	$582.63
40818	Excise oral mucosa for graft	Y	A2	$150.72	2.4520	$104.32	$139.12
40819	Excise lip or cheek fold	Y	A2	$333.00	7.5511	$321.25	$330.06
40820	Treatment of mouth lesion	Y	P3		3.6455	$155.09	$155.09
40830	Repair mouth laceration	Y	G2		2.4520	$104.32	$104.32
40831	Repair mouth laceration	Y	A2	$333.00	7.5511	$321.25	$330.06
40840	Reconstruction of mouth	Y	A2	$446.00	23.3299	$992.52	$582.63
40842	Reconstruction of mouth	Y	A2	$510.00	23.3299	$992.52	$630.63
40843	Reconstruction of mouth	Y	A2	$510.00	23.3299	$992.52	$630.63

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
40844	Reconstruction of mouth	Y	A2	$717.00	38.1991	$1,625.10	$944.03
40845	Reconstruction of mouth	Y	A2	$717.00	38.1991	$1,625.10	$944.03
41000	Drainage of mouth lesion	Y	P3		1.9394	$82.51	$82.51
41005	Drainage of mouth lesion	Y	A2	$150.72	2.4520	$104.32	$139.12
41006	Drainage of mouth lesion	Y	A2	$333.00	23.3299	$992.52	$497.88
41007	Drainage of mouth lesion	Y	A2	$333.00	16.4266	$698.84	$424.46
41008	Drainage of mouth lesion	Y	A2	$333.00	16.4266	$698.84	$424.46
41009	Drainage of mouth lesion	Y	A2	$150.72	2.4520	$104.32	$139.12
41010	Incision of tongue fold	Y	A2	$333.00	7.5511	$321.25	$330.06
41015	Drainage of mouth lesion	Y	A2	$150.72	2.4520	$104.32	$139.12
41016	Drainage of mouth lesion	Y	A2	$333.00	7.5511	$321.25	$330.06
41017	Drainage of mouth lesion	Y	A2	$333.00	7.5511	$321.25	$330.06
41018	Drainage of mouth lesion	Y	A2	$333.00	7.5511	$321.25	$330.06
41100	Biopsy of tongue	Y	P3		2.0118	$85.59	$85.59
41105	Biopsy of tongue	Y	P3		1.9634	$83.53	$83.53
41108	Biopsy of floor of mouth	Y	P3		1.7947	$76.35	$76.35
41110	Excision of tongue lesion	Y	P3		2.5913	$110.24	$110.24
41112	Excision of tongue lesion	Y	A2	$446.00	16.4266	$698.84	$509.21
41113	Excision of tongue lesion	Y	A2	$446.00	16.4266	$698.84	$509.21
41114	Excision of tongue lesion	Y	A2	$446.00	23.3299	$992.52	$582.63
41115	Excision of tongue fold	Y	P3		3.0339	$129.07	$129.07
41116	Excision of mouth lesion	Y	A2	$333.00	16.4266	$698.84	$424.46
41120	Partial removal of tongue	Y	A2	$717.00	23.3299	$992.52	$785.88
41250	Repair tongue laceration	Y	A2	$150.72	2.4520	$104.32	$139.12
41251	Repair tongue laceration	Y	A2	$150.72	2.4520	$104.32	$139.12
41252	Repair tongue laceration	Y	A2	$446.00	7.5511	$321.25	$414.81
41500	Fixation of tongue	Y	A2	$333.00	23.3299	$992.52	$497.88
41510	Tongue to lip surgery	Y	A2	$333.00	16.4266	$698.84	$424.46
41520	Reconstruction, tongue fold	Y	A2	$446.00	7.5511	$321.25	$414.81
41800	Drainage of gum lesion	Y	A2	$88.46	1.4392	$61.23	$81.65
41805	Removal of foreign body, gum	Y	P3		2.9695	$126.33	$126.33
41806	Removal of foreign body, jawbone	Y	P3		3.8145	$162.28	$162.28
41820	Excision, gum, each quadrant	Y	R2		7.5511	$321.25	$321.25
41821	Excision of gum flap	Y	G2		7.5511	$321.25	$321.25
41822	Excision of gum lesion	Y	P3		3.4363	$146.19	$146.19
41823	Excision of gum lesion	Y	P3		4.8525	$206.44	$206.44
41825	Excision of gum lesion	Y	P3		2.6879	$114.35	$114.35
41826	Excision of gum lesion	Y	P3		3.0339	$129.07	$129.07
41827	Excision of gum lesion	Y	A2	$446.00	23.3299	$992.52	$582.63
41828	Excision of gum lesion	Y	P3		3.1867	$135.57	$135.57
41830	Removal of gum tissue	Y	P3		4.4261	$188.30	$188.30
41850	Treatment of gum lesion	Y	R2		16.4266	$698.84	$698.84
41870	Gum graft	Y	G2		23.3299	$992.52	$992.52
41872	Repair gum	Y	P3		4.3939	$186.93	$186.93
41874	Repair tooth socket	Y	P3		4.2651	$181.45	$181.45
42000	Drainage mouth roof lesion	Y	A2	$150.72	2.4520	$104.32	$139.12
42100	Biopsy roof of mouth	Y	P3		1.7220	$73.26	$73.26
42104	Excision lesion, mouth roof	Y	P3		2.3980	$102.02	$102.02
42106	Excision lesion, mouth roof	Y	P3		3.0741	$130.78	$130.78
42107	Excision lesion, mouth roof	Y	A2	$446.00	23.3299	$992.52	$582.63
42120	Remove palate/lesion	Y	A2	$630.00	38.1991	$1,625.10	$878.78
42140	Excision of uvula	Y	A2	$446.00	7.5511	$321.25	$414.81
42145	Repair palate, pharynx/uvula	Y	A2	$717.00	23.3299	$992.52	$785.88
42160	Treatment mouth roof lesion	Y	P3		3.1707	$134.89	$134.89
42180	Repair palate	Y	A2	$150.72	2.4520	$104.32	$139.12
42182	Repair palate	Y	A2	$446.00	38.1991	$1,625.10	$740.78
42200	Reconstruct cleft palate	Y	A2	$717.00	38.1991	$1,625.10	$944.03
42205	Reconstruct cleft palate	Y	A2	$717.00	38.1991	$1,625.10	$944.03
42210	Reconstruct cleft palate	Y	A2	$717.00	38.1991	$1,625.10	$944.03
42215	Reconstruct cleft palate	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
42220	Reconstruct cleft palate	Y	A2	$717.00	38.1991	$1,625.10	$944.03
42226	Lengthening of palate	Y	A2	$717.00	38.1991	$1,625.10	$944.03
42235	Repair palate	Y	A2	$717.00	16.4266	$698.84	$712.46

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
42260	Repair nose to lip fistula	Y	A2	$630.00	23.3299	$992.52	$720.63
42280	Preparation, palate mold	Y	P3		1.6898	$71.89	$71.89
42281	Insertion, palate prosthesis	Y	G2		16.4266	$698.84	$698.84
42300	Drainage of salivary gland	Y	A2	$333.00	16.4266	$698.84	$424.46
42305	Drainage of salivary gland	Y	A2	$446.00	16.4266	$698.84	$509.21
42310	Drainage of salivary gland	Y	A2	$150.72	2.4520	$104.32	$139.12
42320	Drainage of salivary gland	Y	A2	$150.72	2.4520	$104.32	$139.12
42330	Removal of salivary stone	Y	P3		2.5511	$108.53	$108.53
42335	Removal of salivary stone	Y	P3		4.1685	$177.34	$177.34
42340	Removal of salivary stone	Y	A2	$446.00	16.4266	$698.84	$509.21
42400	Biopsy of salivary gland	Y	P3		1.4244	$60.60	$60.60
42405	Biopsy of salivary gland	Y	A2	$446.00	16.4266	$698.84	$509.21
42408	Excision of salivary cyst	Y	A2	$510.00	16.4266	$698.84	$557.21
42409	Drainage of salivary cyst	Y	A2	$510.00	16.4266	$698.84	$557.21
42410	Excise parotid gland/lesion	Y	A2	$510.00	38.1991	$1,625.10	$788.78
42415	Excise parotid gland/lesion	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
42420	Excise parotid gland/lesion	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
42425	Excise parotid gland/lesion	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
42440	Excise submaxillary gland	Y	A2	$510.00	38.1991	$1,625.10	$788.78
42450	Excise sublingual gland	Y	A2	$446.00	23.3299	$992.52	$582.63
42500	Repair salivary duct	Y	A2	$510.00	23.3299	$992.52	$630.63
42505	Repair salivary duct	Y	A2	$630.00	38.1991	$1,625.10	$878.78
42507	Parotid duct diversion	Y	A2	$510.00	38.1991	$1,625.10	$788.78
42508	Parotid duct diversion	Y	A2	$630.00	38.1991	$1,625.10	$878.78
42509	Parotid duct diversion	Y	A2	$630.00	38.1991	$1,625.10	$878.78
42510	Parotid duct diversion	Y	A2	$630.00	38.1991	$1,625.10	$878.78
42550	Injection for salivary x-ray		N1				
42600	Closure of salivary fistula	Y	A2	$333.00	16.4266	$698.84	$424.46
42650	Dilation of salivary duct	Y	P3		0.9254	$39.37	$39.37
42660	Dilation of salivary duct	Y	P3		1.1186	$47.59	$47.59
42665	Ligation of salivary duct	Y	A2	$995.00	23.3299	$992.52	$994.38
42700	Drainage of tonsil abscess	Y	A2	$150.72	2.4520	$104.32	$139.12
42720	Drainage of throat abscess	Y	A2	$333.00	16.4266	$698.84	$424.46
42725	Drainage of throat abscess	Y	A2	$446.00	38.1991	$1,625.10	$740.78
42800	Biopsy of throat	Y	P3		1.7947	$76.35	$76.35
42802	Biopsy of throat	Y	A2	$333.00	16.4266	$698.84	$424.46
42804	Biopsy of upper nose/throat	Y	A2	$333.00	16.4266	$698.84	$424.46
42806	Biopsy of upper nose/throat	Y	A2	$446.00	23.3299	$992.52	$582.63
42808	Excise pharynx lesion	Y	A2	$446.00	16.4266	$698.84	$509.21
42809	Remove pharynx foreign body	N	G2		0.6102	$25.96	$25.96
42810	Excision of neck cyst	Y	A2	$510.00	23.3299	$992.52	$630.63
42815	Excision of neck cyst	Y	A2	$717.00	38.1991	$1,625.10	$944.03
42820	Remove tonsils and adenoids	Y	A2	$510.00	22.1165	$940.90	$617.73
42821	Remove tonsils and adenoids	Y	A2	$717.00	22.1165	$940.90	$772.98
42825	Removal of tonsils	Y	A2	$630.00	22.1165	$940.90	$707.73
42826	Removal of tonsils	Y	A2	$630.00	22.1165	$940.90	$707.73
42830	Removal of adenoids	Y	A2	$630.00	22.1165	$940.90	$707.73
42831	Removal of adenoids	Y	A2	$630.00	22.1165	$940.90	$707.73
42835	Removal of adenoids	Y	A2	$630.00	22.1165	$940.90	$707.73
42836	Removal of adenoids	Y	A2	$630.00	22.1165	$940.90	$707.73
42860	Excision of tonsil tags	Y	A2	$510.00	22.1165	$940.90	$617.73
42870	Excision of lingual tonsil	Y	A2	$510.00	22.1165	$940.90	$617.73
42890	Partial removal of pharynx	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
42892	Revision of pharyngeal walls	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
42900	Repair throat wound	Y	A2	$333.00	7.5511	$321.25	$330.06
42950	Reconstruction of throat	Y	A2	$446.00	23.3299	$992.52	$582.63
42955	Surgical opening of throat	Y	A2	$446.00	23.3299	$992.52	$582.63
42960	Control throat bleeding	Y	A2	$72.48	1.1791	$50.16	$66.90
42962	Control throat bleeding	Y	A2	$446.00	38.1991	$1,625.10	$740.78
42970	Control nose/throat bleeding	Y	R2		1.1791	$50.16	$50.16
42972	Control nose/throat bleeding	Y	A2	$510.00	16.4266	$698.84	$557.21
43030	Throat muscle surgery	Y	G2		16.4266	$698.84	$698.84
43200	Esophagus endoscopy	Y	A2	$333.00	8.3175	$353.85	$338.21

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
43201	Esoph scope w/submucous inj	Y	A2	$333.00	8.3175	$353.85	$338.21
43202	Esophagus endoscopy, biopsy	Y	A2	$333.00	8.3175	$353.85	$338.21
43204	Esoph scope w/sclerosis inj	Y	A2	$333.00	8.3175	$353.85	$338.21
43205	Esophagus endoscopy/ligation	Y	A2	$333.00	8.3175	$353.85	$338.21
43215	Esophagus endoscopy	Y	A2	$333.00	8.3175	$353.85	$338.21
43216	Esophagus endoscopy/lesion	Y	A2	$333.00	8.3175	$353.85	$338.21
43217	Esophagus endoscopy	Y	A2	$333.00	8.3175	$353.85	$338.21
43219	Esophagus endoscopy	Y	A2	$333.00	22.9475	$976.26	$493.82
43220	Esoph endoscopy, dilation	Y	A2	$333.00	8.3175	$353.85	$338.21
43226	Esoph endoscopy, dilation	Y	A2	$333.00	8.3175	$353.85	$338.21
43227	Esoph endoscopy, repair	Y	A2	$446.00	8.3175	$353.85	$422.96
43228	Esoph endoscopy, ablation	Y	A2	$446.00	25.7552	$1,095.70	$608.43
43231	Esoph endoscopy w/us exam	Y	A2	$446.00	8.3175	$353.85	$422.96
43232	Esoph endoscopy w/us fn bx	Y	A2	$446.00	8.3175	$353.85	$422.96
43234	Upper GI endoscopy, exam	Y	A2	$333.00	8.3175	$353.85	$338.21
43235	Uppr gi endoscopy, diagnosis	Y	A2	$333.00	8.3175	$353.85	$338.21
43236	Uppr gi scope w/submuc inj	Y	A2	$446.00	8.3175	$353.85	$422.96
43237	Endoscopic us exam, esoph	Y	A2	$446.00	8.3175	$353.85	$422.96
43238	Uppr gi endoscopy w/us fn bx	Y	A2	$446.00	8.3175	$353.85	$422.96
43239	Upper GI endoscopy, biopsy	Y	A2	$446.00	8.3175	$353.85	$422.96
43240	Esoph endoscope w/drain cyst	Y	A2	$446.00	8.3175	$353.85	$422.96
43241	Upper GI endoscopy with tube	Y	A2	$446.00	8.3175	$353.85	$422.96
43242	Uppr gi endoscopy w/us fn bx	Y	A2	$446.00	8.3175	$353.85	$422.96
43243	Upper gi endoscopy & inject	Y	A2	$446.00	8.3175	$353.85	$422.96
43244	Upper GI endoscopy/ligation	Y	A2	$446.00	8.3175	$353.85	$422.96
43245	Uppr gi scope dilate strictr	Y	A2	$446.00	8.3175	$353.85	$422.96
43246	Place gastrostomy tube	Y	A2	$446.00	8.3175	$353.85	$422.96
43247	Operative upper GI endoscopy	Y	A2	$446.00	8.3175	$353.85	$422.96
43248	Uppr gi endoscopy/guide wire	Y	A2	$446.00	8.3175	$353.85	$422.96
43249	Esoph endoscopy, dilation	Y	A2	$446.00	8.3175	$353.85	$422.96
43250	Upper GI endoscopy/tumor	Y	A2	$446.00	8.3175	$353.85	$422.96
43251	Operative upper GI endoscopy	Y	A2	$446.00	8.3175	$353.85	$422.96
43255	Operative upper GI endoscopy	Y	A2	$446.00	8.3175	$353.85	$422.96
43256	Uppr gi endoscopy w/stent	Y	A2	$510.00	22.9475	$976.26	$626.57
43257	Uppr gi scope w/thrml txmnt	Y	A2	$510.00	25.7552	$1,095.70	$656.43
43258	Operative upper GI endoscopy	Y	A2	$510.00	8.3175	$353.85	$470.96
43259	Endoscopic ultrasound exam	Y	A2	$510.00	8.3175	$353.85	$470.96
43260	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43261	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43262	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43263	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43264	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43265	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43267	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43268	Endo cholangiopancreatograph	Y	A2	$446.00	22.9475	$976.26	$578.57
43269	Endo cholangiopancreatograph	Y	A2	$446.00	22.9475	$976.26	$578.57
43271	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43272	Endo cholangiopancreatograph	Y	A2	$446.00	19.8381	$843.97	$545.49
43450	Dilate esophagus	Y	A2	$333.00	5.4566	$232.14	$307.79
43453	Dilate esophagus	Y	A2	$333.00	5.4566	$232.14	$307.79
43456	Dilate esophagus	Y	A2	$335.41	5.4566	$232.14	$309.59
43458	Dilate esophagus	Y	A2	$335.41	5.4566	$232.14	$309.59
43600	Biopsy of stomach	Y	A2	$333.00	8.3175	$353.85	$338.21
43653	Laparoscopy, gastrostomy	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
43750	Place gastrostomy tube	Y	A2	$446.00	8.3175	$353.85	$422.96
43760	Change gastrostomy tube	Y	A2	$144.98	2.3587	$100.35	$133.82
43761	Reposition gastrostomy tube	Y	A2	$333.00	7.4800	$318.22	$329.31
43870	Repair stomach opening	Y	A2	$333.00	8.3175	$353.85	$338.21
43886	Revise gastric port, open	Y	G2	.....	5.2594	$223.75	$223.75
43887	Remove gastric port, open	Y	G2	.....	5.2594	$223.75	$223.75
43888	Change gastric port, open	Y	G2	.....	14.0346	$597.07	$597.07
44100	Biopsy of bowel	Y	A2	$333.00	8.3175	$353.85	$338.21
44312	Revision of ileostomy	Y	A2	$333.00	21.4302	$911.71	$477.68

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
44340	Revision of colostomy	Y	A2	$510.00	21.4302	$911.71	$610.43
44360	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44361	Small bowel endoscopy/biopsy	Y	A2	$446.00	9.4946	$403.93	$435.48
44363	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44364	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44365	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44366	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44369	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44370	Small bowel endoscopy/stent	Y	A2	$1,339.00	22.9475	$976.26	$1,248.32
44372	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44373	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44376	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44377	Small bowel endoscopy/biopsy	Y	A2	$446.00	9.4946	$403.93	$435.48
44378	Small bowel endoscopy	Y	A2	$446.00	9.4946	$403.93	$435.48
44379	Sbowel endoscope w/stent	Y	A2	$1,339.00	22.9475	$976.26	$1,248.32
44380	Small bowel endoscopy	Y	A2	$333.00	9.4946	$403.93	$350.73
44382	Small bowel endoscopy	Y	A2	$333.00	9.4946	$403.93	$350.73
44383	Ileoscopy w/stent	Y	A2	$1,339.00	22.9475	$976.26	$1,248.32
44385	Endoscopy of bowel pouch	Y	A2	$333.00	8.7686	$373.04	$343.01
44386	Endoscopy, bowel pouch/biop	Y	A2	$333.00	8.7686	$373.04	$343.01
44388	Colonoscopy	Y	A2	$333.00	8.7686	$373.04	$343.01
44389	Colonoscopy with biopsy	Y	A2	$333.00	8.7686	$373.04	$343.01
44390	Colonoscopy for foreign body	Y	A2	$333.00	8.7686	$373.04	$343.01
44391	Colonoscopy for bleeding	Y	A2	$333.00	8.7686	$373.04	$343.01
44392	Colonoscopy & polypectomy	Y	A2	$333.00	8.7686	$373.04	$343.01
44393	Colonoscopy, lesion removal	Y	A2	$333.00	8.7686	$373.04	$343.01
44394	Colonoscopy w/snare	Y	A2	$333.00	8.7686	$373.04	$343.01
44397	Colonoscopy w/stent	Y	A2	$333.00	22.9475	$976.26	$493.82
44701	Intraop colon lavage add-on		N1				
45000	Drainage of pelvic abscess	Y	A2	$312.07	5.0770	$215.99	$288.05
45005	Drainage of rectal abscess	Y	A2	$446.00	12.7389	$541.95	$469.99
45020	Drainage of rectal abscess	Y	A2	$446.00	12.7389	$541.95	$469.99
45100	Biopsy of rectum	Y	A2	$333.00	22.2682	$947.36	$486.59
45108	Removal of anorectal lesion	Y	A2	$446.00	22.2682	$947.36	$571.34
45150	Excision of rectal stricture	Y	A2	$446.00	22.2682	$947.36	$571.34
45160	Excision of rectal lesion	Y	A2	$446.00	22.2682	$947.36	$571.34
45170	Excision of rectal lesion	Y	A2	$446.00	22.2682	$947.36	$571.34
45190	Destruction, rectal tumor	Y	A2	$1,339.00	22.2682	$947.36	$1,241.09
45300	Proctosigmoidoscopy dx	Y	P3		1.3922	$59.23	$59.23
45303	Proctosigmoidoscopy dilate	Y	P2		8.5477	$363.64	$363.64
45305	Proctosigmoidoscopy w/bx	Y	A2	$333.00	8.5477	$363.64	$340.66
45307	Proctosigmoidoscopy fb	Y	A2	$333.00	20.6375	$877.98	$469.25
45308	Proctosigmoidoscopy removal	Y	A2	$333.00	8.5477	$363.64	$340.66
45309	Proctosigmoidoscopy removal	Y	A2	$333.00	8.5477	$363.64	$340.66
45315	Proctosigmoidoscopy removal	Y	A2	$333.00	8.5477	$363.64	$340.66
45317	Proctosigmoidoscopy bleed	Y	A2	$333.00	8.5477	$363.64	$340.66
45320	Proctosigmoidoscopy ablate	Y	A2	$333.00	20.6375	$877.98	$469.25
45321	Proctosigmoidoscopy volvul	Y	A2	$333.00	20.6375	$877.98	$469.25
45327	Proctosigmoidoscopy w/stent	Y	A2	$333.00	22.9475	$976.26	$493.82
45330	Diagnostic sigmoidoscopy	Y	P3		1.9152	$81.48	$81.48
45331	Sigmoidoscopy and biopsy	Y	A2	$299.24	4.8683	$207.11	$276.21
45332	Sigmoidoscopy w/fb removal	Y	A2	$299.24	4.8683	$207.11	$276.21
45333	Sigmoidoscopy & polypectomy	Y	A2	$333.00	8.5477	$363.64	$340.66
45334	Sigmoidoscopy for bleeding	Y	A2	$333.00	8.5477	$363.64	$340.66
45335	Sigmoidoscopy w/submuc inj	Y	A2	$299.24	4.8683	$207.11	$276.21
45337	Sigmoidoscopy & decompress	Y	A2	$299.24	4.8683	$207.11	$276.21
45338	Sigmoidoscopy w/tumr remove	Y	A2	$333.00	8.5477	$363.64	$340.66
45339	Sigmoidoscopy w/ablate tumr	Y	A2	$333.00	8.5477	$363.64	$340.66
45340	Sig w/balloon dilation	Y	A2	$333.00	8.5477	$363.64	$340.66
45341	Sigmoidoscopy w/ultrasound	Y	A2	$333.00	8.5477	$363.64	$340.66
45342	Sigmoidoscopy w/us guide bx	Y	A2	$333.00	8.5477	$363.64	$340.66
45345	Sigmoidoscopy w/stent	Y	A2	$333.00	22.9475	$976.26	$493.82
45355	Surgical colonoscopy	Y	A2	$333.00	8.7686	$373.04	$343.01

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
45378	Diagnostic colonoscopy	Y	A2	$446.00	8.7686	$373.04	$427.76
45379	Colonoscopy w/fb removal	Y	A2	$446.00	8.7686	$373.04	$427.76
45380	Colonoscopy and biopsy	Y	A2	$446.00	8.7686	$373.04	$427.76
45381	Colonoscopy, submucous inj	Y	A2	$446.00	8.7686	$373.04	$427.76
45382	Colonoscopy/control bleeding	Y	A2	$446.00	8.7686	$373.04	$427.76
45383	Lesion removal colonoscopy	Y	A2	$446.00	8.7686	$373.04	$427.76
45384	Lesion remove colonoscopy	Y	A2	$446.00	8.7686	$373.04	$427.76
45385	Lesion removal colonoscopy	Y	A2	$446.00	8.7686	$373.04	$427.76
45386	Colonoscopy dilate stricture	Y	A2	$446.00	8.7686	$373.04	$427.76
45387	Colonoscopy w/stent	Y	A2	$333.00	22.9475	$976.26	$493.82
45391	Colonoscopy w/endoscope us	Y	A2	$446.00	8.7686	$373.04	$427.76
45392	Colonoscopy w/endoscopic fnb	Y	A2	$446.00	8.7686	$373.04	$427.76
45500	Repair of rectum	Y	A2	$446.00	22.2682	$947.36	$571.34
45505	Repair of rectum	Y	A2	$446.00	29.6189	$1,260.08	$649.52
45520	Treatment of rectal prolapse	Y	P2	.....	1.0798	$45.94	$45.94
45560	Repair of rectocele	Y	A2	$446.00	29.6189	$1,260.08	$649.52
45900	Reduction of rectal prolapse	Y	A2	$312.07	5.0770	$215.99	$288.05
45905	Dilation of anal sphincter	Y	A2	$333.00	22.2682	$947.36	$486.59
45910	Dilation of rectal narrowing	Y	A2	$333.00	22.2682	$947.36	$486.59
45915	Remove rectal obstruction	Y	A2	$312.07	5.0770	$215.99	$288.05
45990	Surg dx exam, anorectal	Y	A2	$312.07	5.0770	$215.99	$288.05
46020	Placement of seton	Y	A2	$510.00	22.2682	$947.36	$619.34
46030	Removal of rectal marker	Y	A2	$312.07	5.0770	$215.99	$288.05
46040	Incision of rectal abscess	Y	A2	$510.00	22.2682	$947.36	$619.34
46045	Incision of rectal abscess	Y	A2	$446.00	22.2682	$947.36	$571.34
46050	Incision of anal abscess	Y	A2	$312.07	5.0770	$215.99	$288.05
46060	Incision of rectal abscess	Y	A2	$446.00	22.2682	$947.36	$571.34
46070	Incision of anal septum	Y	G2	.....	12.7389	$541.95	$541.95
46080	Incision of anal sphincter	Y	A2	$510.00	22.2682	$947.36	$619.34
46083	Incise external hemorrhoid	Y	P3	.....	1.9554	$83.19	$83.19
46200	Removal of anal fissure	Y	A2	$446.00	22.2682	$947.36	$571.34
46210	Removal of anal crypt	Y	A2	$446.00	22.2682	$947.36	$571.34
46211	Removal of anal crypts	Y	A2	$446.00	22.2682	$947.36	$571.34
46220	Removal of anal tag	Y	A2	$333.00	22.2682	$947.36	$486.59
46221	Ligation of hemorrhoid(s)	Y	P3	.....	2.5591	$108.87	$108.87
46230	Removal of anal tags	Y	A2	$333.00	22.2682	$947.36	$486.59
46250	Hemorrhoidectomy	Y	A2	$510.00	22.2682	$947.36	$619.34
46255	Hemorrhoidectomy	Y	A2	$510.00	22.2682	$947.36	$619.34
46257	Remove hemorrhoids & fissure	Y	A2	$510.00	22.2682	$947.36	$619.34
46258	Remove hemorrhoids & fistula	Y	A2	$510.00	22.2682	$947.36	$619.34
46260	Hemorrhoidectomy	Y	A2	$510.00	22.2682	$947.36	$619.34
46261	Remove hemorrhoids & fissure	Y	A2	$630.00	22.2682	$947.36	$709.34
46262	Remove hemorrhoids & fistula	Y	A2	$630.00	22.2682	$947.36	$709.34
46270	Removal of anal fistula	Y	A2	$510.00	22.2682	$947.36	$619.34
46275	Removal of anal fistula	Y	A2	$510.00	22.2682	$947.36	$619.34
46280	Removal of anal fistula	Y	A2	$630.00	22.2682	$947.36	$709.34
46285	Removal of anal fistula	Y	A2	$333.00	22.2682	$947.36	$486.59
46288	Repair anal fistula	Y	A2	$630.00	22.2682	$947.36	$709.34
46320	Removal of hemorrhoid clot	Y	P3	.....	1.8186	$77.37	$77.37
46500	Injection into hemorrhoid(s)	Y	P3	.....	2.2934	$97.57	$97.57
46505	Chemodenervation anal musc	Y	G2	.....	5.0770	$215.99	$215.99
46600	Diagnostic anoscopy	N	P2	.....	0.6102	$25.96	$25.96
46604	Anoscopy and dilation	Y	P2	.....	8.5477	$363.64	$363.64
46606	Anoscopy and biopsy	Y	P3	.....	3.0821	$131.12	$131.12
46608	Anoscopy, remove for body	Y	A2	$333.00	8.5477	$363.64	$340.66
46610	Anoscopy, remove lesion	Y	A2	$333.00	20.6375	$877.98	$469.25
46611	Anoscopy	Y	A2	$333.00	8.5477	$363.64	$340.66
46612	Anoscopy, remove lesions	Y	A2	$333.00	20.6375	$877.98	$469.25
46614	Anoscopy, control bleeding	Y	P3	.....	1.9634	$83.53	$83.53
46615	Anoscopy	Y	A2	$446.00	20.6375	$877.98	$554.00
46700	Repair of anal stricture	Y	A2	$510.00	22.2682	$947.36	$619.34
46706	Repr of anal fistula w/glue	Y	A2	$333.00	29.6189	$1,260.08	$564.77
46750	Repair of anal sphincter	Y	A2	$510.00	37.8991	$1,612.34	$785.59

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
46753	Reconstruction of anus	Y	A2	$510.00	22.2682	$947.36	$619.34
46754	Removal of suture from anus	Y	A2	$446.00	22.2682	$947.36	$571.34
46760	Repair of anal sphincter	Y	A2	$446.00	37.8991	$1,612.34	$737.59
46761	Repair of anal sphincter	Y	A2	$510.00	37.8991	$1,612.34	$785.59
46762	Implant artificial sphincter	Y	A2	$995.00	37.8991	$1,612.34	$1,149.34
46900	Destruction, anal lesion(s)	Y	P3		2.4947	$106.13	$106.13
46910	Destruction, anal lesion(s)	Y	P3		2.7281	$116.06	$116.06
46916	Cryosurgery, anal lesion(s)	Y	P2		1.0918	$46.45	$46.45
46917	Laser surgery, anal lesions	Y	A2	$333.00	20.4276	$869.05	$467.01
46922	Excision of anal lesion(s)	Y	A2	$333.00	20.4276	$869.05	$467.01
46924	Destruction, anal lesion(s)	Y	A2	$333.00	20.4276	$869.05	$467.01
46934	Destruction of hemorrhoids	Y	P3		4.2087	$179.05	$179.05
46935	Destruction of hemorrhoids	Y	P3		2.8729	$122.22	$122.22
46936	Destruction of hemorrhoids	Y	P3		4.4341	$188.64	$188.64
46937	Cryotherapy of rectal lesion	Y	A2	$446.00	22.2682	$947.36	$571.34
46938	Cryotherapy of rectal lesion	Y	A2	$446.00	29.6189	$1,260.08	$649.52
46940	Treatment of anal fissure	Y	P3		1.9394	$82.51	$82.51
46942	Treatment of anal fissure	Y	P3		1.8588	$79.08	$79.08
46945	Ligation of hemorrhoids	Y	P3		3.2511	$138.31	$138.31
46946	Ligation of hemorrhoids	Y	A2	$333.00	12.7389	$541.95	$385.24
46947	Hemorrhoidopexy by stapling	Y	A2	$995.00	29.6189	$1,260.08	$1,061.27
47000	Needle biopsy of liver	Y	A2	$333.00	6.1384	$261.15	$315.04
47001	Needle biopsy, liver add-on		N1				
47382	Percut ablate liver rf	Y	G2		37.3604	$1,589.42	$1,589.42
47500	Injection for liver x-rays		N1				
47505	Injection for liver x-rays		N1				
47510	Insert catheter, bile duct	Y	A2	$446.00	20.2682	$862.27	$550.07
47511	Insert bile duct drain	Y	A2	$1,245.85	20.2682	$862.27	$1,149.96
47525	Change bile duct catheter	Y	A2	$333.00	11.6575	$495.95	$373.74
47530	Revise/reinsert bile tube	Y	A2	$333.00	11.6575	$495.95	$373.74
47552	Biliary endoscopy thru skin	Y	A2	$446.00	20.2682	$862.27	$550.07
47553	Biliary endoscopy thru skin	Y	A2	$510.00	20.2682	$862.27	$598.07
47554	Biliary endoscopy thru skin	Y	A2	$510.00	20.2682	$862.27	$598.07
47555	Biliary endoscopy thru skin	Y	A2	$510.00	20.2682	$862.27	$598.07
47556	Biliary endoscopy thru skin	Y	A2	$1,245.85	20.2682	$862.27	$1,149.96
47560	Laparoscopy w/cholangio	Y	A2	$510.00	32.1241	$1,366.66	$724.17
47561	Laparo w/cholangio/biopsy	Y	A2	$510.00	32.1241	$1,366.66	$724.17
47562	Laparoscopic cholecystectomy	Y	G2		43.5488	$1,852.70	$1,852.70
47563	Laparo cholecystectomy/graph	Y	G2		43.5488	$1,852.70	$1,852.70
47564	Laparo cholecystectomy/explr	Y	G2		43.5488	$1,852.70	$1,852.70
47630	Remove bile duct stone	Y	A2	$510.00	20.2682	$862.27	$598.07
48102	Needle biopsy, pancreas	Y	A2	$333.00	6.1384	$261.15	$315.04
49080	Puncture, peritoneal cavity	Y	A2	$222.78	3.6244	$154.19	$205.63
49081	Removal of abdominal fluid	Y	A2	$222.78	3.6244	$154.19	$205.63
49180	Biopsy, abdominal mass	Y	A2	$333.00	6.1384	$261.15	$315.04
49250	Excision of umbilicus	Y	A2	$630.00	22.0832	$939.49	$707.37
49320	Diag laparo separate proc	Y	A2	$510.00	32.1241	$1,366.66	$724.17
49321	Laparoscopy, biopsy	Y	A2	$630.00	32.1241	$1,366.66	$814.17
49322	Laparoscopy, aspiration	Y	A2	$630.00	32.1241	$1,366.66	$814.17
49400	Air injection into abdomen		N1				
49402	Remove foreign body, adbomen	Y	A2	$446.00	22.0832	$939.49	$569.37
49419	Insrt abdom cath for chemotx	Y	A2	$333.00	29.2133	$1,242.82	$560.46
49420	Insert abdom drain, temp	Y	A2	$333.00	29.5416	$1,256.79	$563.95
49421	Insert abdom drain, perm	Y	A2	$333.00	29.5416	$1,256.79	$563.95
49422	Remove perm cannula/catheter	Y	A2	$333.00	25.6142	$1,089.70	$522.18
49423	Exchange drainage catheter	Y	G2		11.6575	$495.95	$495.95
49424	Assess cyst, contrast inject		N1				
49426	Revise abdomen-venous shunt	Y	A2	$446.00	22.0832	$939.49	$569.37
49427	Injection, abdominal shunt		N1				
49429	Removal of shunt	Y	G2		25.6142	$1,089.70	$1,089.70
49495	Rpr ing hernia baby, reduc	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49496	Rpr ing hernia baby, blocked	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49500	Rpr ing hernia, init, reduce	Y	A2	$630.00	29.2182	$1,243.03	$783.26

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
49501	Rpr ing hernia, init blocked	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49505	Prp i/hern init reduc > 5 yr	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49507	Prp i/hern init block > 5 yr	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49520	Rerepair ing hernia, reduce	Y	A2	$995.00	29.2182	$1,243.03	$1,057.01
49521	Rerepair ing hernia, blocked	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49525	Repair ing hernia, sliding	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49540	Repair lumbar hernia	Y	A2	$446.00	29.2182	$1,243.03	$645.26
49550	Rpr rem hernia, init, reduce	Y	A2	$717.00	29.2182	$1,243.03	$848.51
49553	Rpr fem hernia, init blocked	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49555	Rerepair fem hernia, reduce	Y	A2	$717.00	29.2182	$1,243.03	$848.51
49557	Rerepair fem hernia, blocked	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49560	Rpr ventral hern init, reduc	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49561	Rpr ventral hern init, block	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49565	Rerepair ventrl hern, reduce	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49566	Rerepair ventrl hern, block	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49568	Hernia repair w/mesh	Y	A2	$995.00	29.2182	$1,243.03	$1,057.01
49570	Rpr epigastric hern, reduce	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49572	Rpr epigastric hern, blocked	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49580	Rpr umbil hern, reduc < 5 yr	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49582	Rpr umbil hern, block < 5 yr	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49585	Rpr umbil hern, reduc > 5 yr	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49587	Rpr umbil hern, block > 5 yr	Y	A2	$1,339.00	29.2182	$1,243.03	$1,315.01
49590	Repair spigelian hernia	Y	A2	$510.00	29.2182	$1,243.03	$693.26
49600	Repair umbilical lesion	Y	A2	$630.00	29.2182	$1,243.03	$783.26
49650	Laparo hernia repair initial	Y	A2	$630.00	43.5488	$1,852.70	$935.68
49651	Laparo hernia repair recur	Y	A2	$995.00	43.5488	$1,852.70	$1,209.43
50200	Biopsy of kidney	Y	A2	$333.00	6.1384	$261.15	$315.04
50382	Change ureter stent, percut	Y	G2	.....	19.2251	$817.89	$817.89
50384	Remove ureter stent, percut	Y	G2	.....	19.2251	$817.89	$817.89
50387	Change ext/int ureter stent	Y	G2	.....	7.4800	$318.22	$318.22
50389	Remove renal tube w/fluoro	Y	G2	.....	3.4079	$144.98	$144.98
50390	Drainage of kidney lesion	Y	A2	$333.00	6.1384	$261.15	$315.04
50391	Instll rx agnt into rnal tub	Y	P2	.....	1.0887	$46.32	$46.32
50392	Insert kidney drain	Y	A2	$333.00	19.2251	$817.89	$454.22
50393	Insert ureteral tube	Y	A2	$333.00	19.2251	$817.89	$454.22
50394	Injection for kidney x-ray	.....	N1	.....	.....	.....	.....
50395	Create passage to kidney	Y	A2	$333.00	19.2251	$817.89	$454.22
50396	Measure kidney pressure	Y	A2	$131.50	2.1393	$91.01	$121.38
50398	Change kidney tube	Y	A2	$333.00	7.4800	$318.22	$329.31
50551	Kidney endoscopy	Y	A2	$333.00	6.4951	$276.32	$318.83
50553	Kidney endoscopy	Y	A2	$333.00	19.2251	$817.89	$454.22
50555	Kidney endoscopy & biopsy	Y	A2	$333.00	6.4951	$276.32	$318.83
50557	Kidney endoscopy & treatment	Y	A2	$333.00	23.8700	$1,015.50	$503.63
50561	Kidney endoscopy & treatment	Y	A2	$333.00	19.2251	$817.89	$454.22
50562	Renal scope w/tumor resect	Y	G2	.....	6.4951	$276.32	$276.32
50570	Kidney endoscopy	Y	G2	.....	6.4951	$276.32	$276.32
50572	Kidney endoscopy	Y	G2	.....	6.4951	$276.32	$276.32
50574	Kidney endoscopy & biopsy	Y	G2	.....	6.4951	$276.32	$276.32
50575	Kidney endoscopy	Y	G2	.....	34.9261	$1,485.86	$1,485.86
50576	Kidney endoscopy & treatment	Y	G2	.....	19.2251	$817.89	$817.89
50590	Fragmenting of kidney stone	Y	G2	.....	43.5398	$1,852.31	$1,852.31
50592	Perc rf ablate renal tumor	Y	G2	.....	37.3604	$1,589.42	$1,589.42
50684	Injection for ureter x-ray	.....	N1	.....	.....	.....	.....
50686	Measure ureter pressure	Y	P2	.....	1.0887	$46.32	$46.32
50688	Change of ureter tube/stent	Y	A2	$333.00	7.4800	$318.22	$329.31
50690	Injection for ureter x-ray	.....	N1	.....	.....	.....	.....
50947	Laparo new ureter/bladder	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
50948	Laparo new ureter/bladder	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
50951	Endoscopy of ureter	Y	A2	$333.00	6.4951	$276.32	$318.83
50953	Endoscopy of ureter	Y	A2	$333.00	6.4951	$276.32	$318.83
50955	Ureter endoscopy & biopsy	Y	A2	$333.00	19.2251	$817.89	$454.22
50957	Ureter endoscopy & treatment	Y	A2	$333.00	19.2251	$817.89	$454.22
50961	Ureter endoscopy & treatment	Y	A2	$333.00	19.2251	$817.89	$454.22

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
50970	Ureter endoscopy	Y	A2	$333.00	6.4951	$276.32	$318.83
50972	Ureter endoscopy & catheter	Y	A2	$333.00	6.4951	$276.32	$318.83
50974	Ureter endoscopy & biopsy	Y	A2	$333.00	19.2251	$817.89	$454.22
50976	Ureter endoscopy & treatment	Y	A2	$333.00	19.2251	$817.89	$454.22
50980	Ureter endoscopy & treatment	Y	A2	$333.00	19.2251	$817.89	$454.22
51000	Drainage of bladder	Y	P3	.....	1.1588	$49.30	$49.30
51005	Drainage of bladder	Y	P2	.....	1.0887	$46.32	$46.32
51010	Drainage of bladder	Y	A2	$333.00	18.1679	$772.92	$442.98
51020	Incise & treat bladder	Y	A2	$630.00	23.8700	$1,015.50	$726.38
51030	Incise & treat bladder	Y	A2	$630.00	23.8700	$1,015.50	$726.38
51040	Incise & drain bladder	Y	A2	$630.00	23.8700	$1,015.50	$726.38
51045	Incise bladder/drain ureter	Y	A2	$399.24	6.4951	$276.32	$368.51
51050	Removal of bladder stone	Y	A2	$630.00	23.8700	$1,015.50	$726.38
51065	Remove ureter calculus	Y	A2	$630.00	23.8700	$1,015.50	$726.38
51080	Drainage of bladder abscess	Y	A2	$333.00	17.5086	$744.87	$435.97
51500	Removal of bladder cyst	Y	A2	$630.00	29.2182	$1,243.03	$783.26
51520	Removal of bladder lesion	Y	A2	$630.00	23.8700	$1,015.50	$726.38
51600	Injection for bladder x-ray	.....	N1	.....	.....	.....	.....
51605	Preparation for bladder xray	.....	N1	.....	.....	.....	.....
51610	Injection for bladder x-ray	.....	N1	.....	.....	.....	.....
51700	Irrigation of bladder	Y	P3	.....	1.2554	$53.41	$53.41
51701	Insert bladder catheter	N	P2	.....	0.6102	$25.96	$25.96
51702	Insert temp bladder cath	N	P2	.....	0.6102	$25.96	$25.96
51703	Insert bladder cath, complex	Y	P2	.....	1.0887	$46.32	$46.32
51705	Change of bladder tube	Y	P3	.....	1.7302	$73.61	$73.61
51710	Change of bladder tube	Y	A2	$333.00	7.4800	$318.22	$329.31
51715	Endoscopic injection/implant	Y	A2	$510.00	29.0253	$1,234.82	$691.21
51720	Treatment of bladder lesion	Y	P3	.....	1.3600	$57.86	$57.86
51725	Simple cystometrogram	Y	P2	.....	2.1393	$91.01	$91.01
51726	Complex cystometrogram	Y	A2	$209.48	3.4079	$144.98	$193.36
51736	Urine flow measurement	Y	P3	.....	0.4264	$18.14	$18.14
51741	Electro-uroflowmetry, first	Y	P3	.....	0.4990	$21.23	$21.23
51772	Urethra pressure profile	Y	A2	$131.50	2.1393	$91.01	$121.38
51784	Anal/urinary muscle study	Y	P2	.....	1.0887	$46.32	$46.32
51785	Anal/urinary muscle study	Y	A2	$66.92	1.0887	$46.32	$61.77
51792	Urinary reflex study	Y	P2	.....	1.0887	$46.32	$46.32
51795	Urine voiding pressure study	Y	P2	.....	2.1393	$91.01	$91.01
51797	Intraabdominal pressure test	Y	P2	.....	2.1393	$91.01	$91.01
51798	Us urine capacity measure	N	P3	.....	0.3702	$15.75	$15.75
51880	Repair of bladder opening	Y	A2	$333.00	23.8700	$1,015.50	$503.63
51992	Laparo sling operation	Y	A2	$717.00	43.5488	$1,852.70	$1,000.93
52000	Cystoscopy	Y	A2	$333.00	6.4951	$276.32	$318.83
52001	Cystoscopy, removal of clots	Y	A2	$399.24	6.4951	$276.32	$368.51
52005	Cystoscopy & ureter catheter	Y	A2	$446.00	19.2251	$817.89	$538.97
52007	Cystoscopy and biopsy	Y	A2	$446.00	19.2251	$817.89	$538.97
52010	Cystoscopy & duct catheter	Y	A2	$399.24	6.4951	$276.32	$368.51
52204	Cystoscopy w/biopsy(s)	Y	A2	$446.00	19.2251	$817.89	$538.97
52214	Cystoscopy and treatment	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52224	Cystoscopy and treatment	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52234	Cystoscopy and treatment	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52235	Cystoscopy and treatment	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52240	Cystoscopy and treatment	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52250	Cystoscopy and radiotracer	Y	A2	$630.00	23.8700	$1,015.50	$726.38
52260	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52265	Cystoscopy and treatment	Y	P2	.....	6.4951	$276.32	$276.32
52270	Cystoscopy & revise urethra	Y	A2	$446.00	19.2251	$817.89	$538.97
52275	Cystoscopy & revise urethra	Y	A2	$446.00	19.2251	$817.89	$538.97
52276	Cystoscopy and treatment	Y	A2	$510.00	19.2251	$817.89	$586.97
52277	Cystoscopy and treatment	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52281	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52282	Cystoscopy, implant stent	Y	A2	$1,339.00	34.9261	$1,485.86	$1,375.72
52283	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52285	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
52290	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52300	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52301	Cystoscopy and treatment	Y	A2	$510.00	19.2251	$817.89	$586.97
52305	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52310	Cystoscopy and treatment	Y	A2	$399.24	6.4951	$276.32	$368.51
52315	Cystoscopy and treatment	Y	A2	$446.00	19.2251	$817.89	$538.97
52317	Remove bladder stone	Y	A2	$333.00	23.8700	$1,015.50	$503.63
52318	Remove bladder stone	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52320	Cystoscopy and treatment	Y	A2	$717.00	23.8700	$1,015.50	$791.63
52325	Cystoscopy, stone removal	Y	A2	$630.00	23.8700	$1,015.50	$726.38
52327	Cystoscopy, inject material	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52330	Cystoscopy and treatment	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52332	Cystoscopy and treatment	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52334	Create passage to kidney	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52341	Cysto w/ureter stricture tx	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52342	Cysto w/up stricture tx	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52343	Cysto w/renal stricture tx	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52344	Cysto/uretero, stricture tx	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52345	Cysto/uretero w/up stricture	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52346	Cystouretero w/renal strict	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52351	Cystouretero & or pyeloscope	Y	A2	$510.00	19.2251	$817.89	$586.97
52352	Cystouretero w/stone remove	Y	A2	$630.00	23.8700	$1,015.50	$726.38
52353	Cystouretero w/lithotripsy	Y	A2	$630.00	34.9261	$1,485.86	$843.97
52354	Cystouretero w/biopsy	Y	A2	$630.00	23.8700	$1,015.50	$726.38
52355	Cystouretero w/excise tumor	Y	A2	$630.00	23.8700	$1,015.50	$726.38
52400	Cystouretero w/congen repr	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52402	Cystourethro cut ejacul duct	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52450	Incision of prostate	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52500	Revision of bladder neck	Y	A2	$510.00	23.8700	$1,015.50	$636.38
52510	Dilation prostatic urethra	Y	A2	$510.00	19.2251	$817.89	$586.97
52601	Prostatectomy (TURP)	Y	A2	$630.00	34.9261	$1,485.86	$843.97
52606	Control postop bleeding	Y	A2	$333.00	23.8700	$1,015.50	$503.63
52612	Prostatectomy, first stage	Y	A2	$446.00	34.9261	$1,485.86	$705.97
52614	Prostatectomy, second stage	Y	A2	$333.00	34.9261	$1,485.86	$621.22
52620	Remove residual prostate	Y	A2	$333.00	34.9261	$1,485.86	$621.22
52630	Remove prostate regrowth	Y	A2	$446.00	34.9261	$1,485.86	$705.97
52640	Relieve bladder contracture	Y	A2	$446.00	23.8700	$1,015.50	$588.38
52647	Laser surgery of prostate	Y	A2	$1,339.00	43.1004	$1,833.62	$1,462.66
52648	Laser surgery of prostate	Y	A2	$1,339.00	43.1004	$1,833.62	$1,462.66
52700	Drainage of prostate abscess	Y	A2	$446.00	23.8700	$1,015.50	$588.38
53000	Incision of urethra	Y	A2	$333.00	18.3960	$782.62	$445.41
53010	Incision of urethra	Y	A2	$333.00	18.3960	$782.62	$445.41
53020	Incision of urethra	Y	A2	$333.00	18.3960	$782.62	$445.41
53025	Incision of urethra	Y	R2	.....	18.3960	$782.62	$782.62
53040	Drainage of urethra abscess	Y	A2	$446.00	18.3960	$782.62	$530.16
53060	Drainage of urethra abscess	Y	P3	.....	1.6416	$69.84	$69.84
53080	Drainage of urinary leakage	Y	A2	$510.00	18.3960	$782.62	$578.16
53085	Drainage of urinary leakage	Y	G2	.....	18.3960	$782.62	$782.62
53200	Biopsy of urethra	Y	A2	$333.00	18.3960	$782.62	$445.41
53210	Removal of urethra	Y	A2	$717.00	29.0253	$1,234.82	$846.46
53215	Removal of urethra	Y	A2	$717.00	18.3960	$782.62	$733.41
53220	Treatment of urethra lesion	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53230	Removal of urethra lesion	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53235	Removal of urethra lesion	Y	A2	$510.00	18.3960	$782.62	$578.16
53240	Surgery for urethra pouch	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53250	Removal of urethra gland	Y	A2	$446.00	18.3960	$782.62	$530.16
53260	Treatment of urethra lesion	Y	A2	$446.00	18.3960	$782.62	$530.16
53265	Treatment of urethra lesion	Y	A2	$446.00	18.3960	$782.62	$530.16
53270	Removal of urethra gland	Y	A2	$446.00	18.3960	$782.62	$530.16
53275	Repair of urethra defect	Y	A2	$446.00	18.3960	$782.62	$530.16
53400	Revise urethra, stage 1	Y	A2	$510.00	29.0253	$1,234.82	$691.21
53405	Revise urethra, stage 2	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53410	Reconstruction of urethra	Y	A2	$446.00	29.0253	$1,234.82	$643.21

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
53420	Reconstruct urethra, stage 1	Y	A2	$510.00	29.0253	$1,234.82	$691.21
53425	Reconstruct urethra, stage 2	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53430	Reconstruction of urethra	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53431	Reconstruct urethra/bladder	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53440	Male sling procedure	N	A2	$446.00	79.2092	$3,369.80	$1,176.95
53442	Remove/revise male sling	Y	A2	$333.00	29.0253	$1,234.82	$558.46
53444	Insert tandem cuff	N	A2	$446.00	79.2092	$3,369.80	$1,176.95
53445	Insert uro/ves nck sphincter	N	H8	$333.00	178.7754	$7,605.64	$6,152.75
53446	Remove uro sphincter	Y	A2	$333.00	29.0253	$1,234.82	$558.46
53447	Remove/replace ur sphincter	N	H8	$333.00	178.7754	$7,605.64	$6,152.75
53449	Repair uro sphincter	Y	A2	$333.00	29.0253	$1,234.82	$558.46
53450	Revision of urethra	Y	A2	$333.00	29.0253	$1,234.82	$558.46
53460	Revision of urethra	Y	A2	$333.00	18.3960	$782.62	$445.41
53502	Repair of urethra injury	Y	A2	$446.00	18.3960	$782.62	$530.16
53505	Repair of urethra injury	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53510	Repair of urethra injury	Y	A2	$446.00	18.3960	$782.62	$530.16
53515	Repair of urethra injury	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53520	Repair of urethra defect	Y	A2	$446.00	29.0253	$1,234.82	$643.21
53600	Dilate urethra stricture	Y	P3	.....	0.9254	$39.37	$39.37
53601	Dilate urethra stricture	Y	P3	.....	1.0702	$45.53	$45.53
53605	Dilate urethra stricture	Y	A2	$446.00	19.2251	$817.89	$538.97
53620	Dilate urethra stricture	Y	P3	.....	1.4888	$63.34	$63.34
53621	Dilate urethra stricture	Y	P3	.....	1.5692	$66.76	$66.76
53660	Dilation of urethra	Y	P3	.....	1.0542	$44.85	$44.85
53661	Dilation of urethra	Y	P3	.....	1.0462	$44.51	$44.51
53665	Dilation of urethra	Y	A2	$333.00	18.3960	$782.62	$445.41
53850	Prostatic microwave thermotx	Y	P2	.....	41.1375	$1,750.11	$1,750.11
53852	Prostatic rf thermotx	Y	P2	.....	41.1375	$1,750.11	$1,750.11
53853	Prostatic water thermother	Y	P2	.....	23.8700	$1,015.50	$1,015.50
54000	Slitting of prepuce	Y	A2	$446.00	18.3960	$782.62	$530.16
54001	Slitting of prepuce	Y	A2	$446.00	18.3960	$782.62	$530.16
54015	Drain penis lesion	Y	A2	$630.00	17.5086	$744.87	$658.72
54050	Destruction, penis lesion(s)	Y	P2	.....	1.0918	$46.45	$46.45
54055	Destruction, penis lesion(s)	Y	P3	.....	1.4404	$61.28	$61.28
54056	Cryosurgery, penis lesion(s)	Y	P2	.....	0.8432	$35.87	$35.87
54057	Laser surg, penis lesion(s)	Y	A2	$333.00	17.4423	$742.05	$435.26
54060	Excision of penis lesion(s)	Y	A2	$333.00	17.4423	$742.05	$435.26
54065	Destruction, penis lesion(s)	Y	A2	$333.00	20.4276	$869.05	$467.01
54100	Biopsy of penis	Y	A2	$333.00	15.1024	$642.50	$410.38
54105	Biopsy of penis	Y	A2	$333.00	20.0656	$853.65	$463.16
54110	Treatment of penis lesion	Y	A2	$446.00	32.9873	$1,403.38	$685.35
54111	Treat penis lesion, graft	Y	A2	$446.00	32.9873	$1,403.38	$685.35
54112	Treat penis lesion, graft	Y	A2	$446.00	32.9873	$1,403.38	$685.35
54115	Treatment of penis lesion	Y	A2	$333.00	17.5086	$744.87	$435.97
54120	Partial removal of penis	Y	A2	$446.00	32.9873	$1,403.38	$685.35
54150	Circumcision w/regionl block	Y	A2	$333.00	20.5513	$874.31	$468.33
54160	Circumcision, neonate	Y	A2	$446.00	20.5513	$874.31	$553.08
54161	Circum 28 days or older	Y	A2	$446.00	20.5513	$874.31	$553.08
54162	Lysis penil circumic lesion	Y	A2	$446.00	20.5513	$874.31	$553.08
54163	Repair of circumcision	Y	A2	$446.00	20.5513	$874.31	$553.08
54164	Frenulotomy of penis	Y	A2	$446.00	20.5513	$874.31	$553.08
54200	Treatment of penis lesion	Y	P3	.....	1.5370	$65.39	$65.39
54205	Treatment of penis lesion	Y	A2	$630.00	32.9873	$1,403.38	$823.35
54220	Treatment of penis lesion	Y	A2	$131.50	2.1393	$91.01	$121.38
54230	Prepare penis study	.....	N1	.....	.....	.....	.....
54231	Dynamic cavernosometry	Y	P3	.....	1.3036	$55.46	$55.46
54235	Penile injection	Y	P3	.....	0.9496	$40.40	$40.40
54240	Penis study	Y	P3	.....	0.6518	$27.73	$27.73
54250	Penis study	Y	P3	.....	0.2254	$9.59	$9.59
54300	Revision of penis	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54304	Revision of penis	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54308	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54312	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
54316	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54318	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54322	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54324	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54326	Reconstruction of urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54328	Revise penis/urethra	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54340	Secondary urethral surgery	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54344	Secondary urethral surgery	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54348	Secondary urethral surgery	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54352	Reconstruct urethra/penis	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54360	Penis plastic surgery	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54380	Repair penis	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54385	Repair penis	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54400	Insert semi-rigid prosthesis	N	A2	$510.00	79.2092	$3,369.80	$1,224.95
54401	Insert self-contd prosthesis	N	H8	$510.00	178.7754	$7,605.64	$6,285.50
54405	Insert multi-comp penis pros	N	H8	$510.00	178.7754	$7,605.64	$6,285.50
54406	Remove muti-comp penis pros	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54408	Repair multi-comp penis pros	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54410	Remove/replace penis prosth	N	H8	$510.00	178.7754	$7,605.64	$6,285.50
54415	Remove self-contd penis pros	Y	A2	$510.00	32.9873	$1,403.38	$733.35
54416	Remv/repl penis contain pros	N	H8	$510.00	178.7754	$7,605.64	$6,285.50
54420	Revision of penis	Y	A2	$630.00	32.9873	$1,403.38	$823.35
54435	Revision of penis	Y	A2	$630.00	32.9873	$1,403.38	$823.35
54440	Repair of penis	Y	A2	$630.00	32.9873	$1,403.38	$823.35
54450	Preputial stretching	Y	A2	$209.48	3.4079	$144.98	$193.36
54500	Biopsy of testis	Y	A2	$333.00	10.2655	$436.73	$358.93
54505	Biopsy of testis	Y	A2	$333.00	23.5310	$1,001.08	$500.02
54512	Excise lesion testis	Y	A2	$446.00	23.5310	$1,001.08	$584.77
54520	Removal of testis	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54522	Orchiectomy, partial	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54530	Removal of testis	Y	A2	$630.00	29.2182	$1,243.03	$783.26
54550	Exploration for testis	Y	A2	$630.00	29.2182	$1,243.03	$783.26
54560	Exploration for testis	Y	G2	.....	23.5310	$1,001.08	$1,001.08
54600	Reduce testis torsion	Y	A2	$630.00	23.5310	$1,001.08	$722.77
54620	Suspension of testis	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54640	Suspension of testis	Y	A2	$630.00	29.2182	$1,243.03	$783.26
54660	Revision of testis	Y	A2	$446.00	23.5310	$1,001.08	$584.77
54670	Repair testis injury	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54680	Relocation of testis(es)	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54690	Laparoscopy, orchiectomy	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
54692	Laparoscopy, orchiopexy	Y	G2	.....	70.5066	$2,999.56	$2,999.56
54700	Drainage of scrotum	Y	A2	$446.00	23.5310	$1,001.08	$584.77
54800	Biopsy of epididymis	Y	A2	$127.16	2.0687	$88.01	$117.37
54830	Remove epididymis lesion	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54840	Remove epididymis lesion	Y	A2	$630.00	23.5310	$1,001.08	$722.77
54860	Removal of epididymis	Y	A2	$510.00	23.5310	$1,001.08	$632.77
54861	Removal of epididymis	Y	A2	$630.00	23.5310	$1,001.08	$722.77
54865	Explore epididymis	Y	A2	$333.00	23.5310	$1,001.08	$500.02
54900	Fusion of spermatic ducts	Y	A2	$630.00	23.5310	$1,001.08	$722.77
54901	Fusion of spermatic ducts	Y	A2	$630.00	23.5310	$1,001.08	$722.77
55000	Drainage of hydrocele	Y	P3	.....	1.5772	$67.10	$67.10
55040	Removal of hydrocele	Y	A2	$510.00	29.2182	$1,243.03	$693.26
55041	Removal of hydroceles	Y	A2	$717.00	29.2182	$1,243.03	$848.51
55060	Repair of hydrocele	Y	A2	$630.00	23.5310	$1,001.08	$722.77
55100	Drainage of scrotum abscess	Y	A2	$333.00	11.1535	$474.50	$368.38
55110	Explore scrotum	Y	A2	$446.00	23.5310	$1,001.08	$584.77
55120	Removal of scrotum lesion	Y	A2	$446.00	23.5310	$1,001.08	$584.77
55150	Removal of scrotum	Y	A2	$333.00	23.5310	$1,001.08	$500.02
55175	Revision of scrotum	Y	A2	$333.00	23.5310	$1,001.08	$500.02
55180	Revision of scrotum	Y	A2	$446.00	23.5310	$1,001.08	$584.77
55200	Incision of sperm duct	Y	A2	$446.00	23.5310	$1,001.08	$584.77
55250	Removal of sperm duct(s)	Y	A2	$446.00	23.5310	$1,001.08	$584.77
55300	Prepare, sperm duct x-ray	.....	N1	.....	.....	.....	.....

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
55400	Repair of sperm duct	Y	A2	$333.00	23.5310	$1,001.08	$500.02
55450	Ligation of sperm duct	Y	P3		5.2227	$222.19	$222.19
55500	Removal of hydrocele	Y	A2	$510.00	23.5310	$1,001.08	$632.77
55520	Removal of sperm cord lesion	Y	A2	$630.00	23.5310	$1,001.08	$722.77
55530	Revise spermatic cord veins	Y	A2	$630.00	23.5310	$1,001.08	$722.77
55535	Revise spermatic cord veins	Y	A2	$630.00	29.2182	$1,243.03	$783.26
55540	Revise hernia & sperm veins	Y	A2	$717.00	29.2182	$1,243.03	$848.51
55550	Laparo ligate spermatic vein	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
55600	Incise sperm duct pouch	Y	R2		23.5310	$1,001.08	$1,001.08
55680	Remove sperm pouch lesion	Y	A2	$333.00	23.5310	$1,001.08	$500.02
55700	Biopsy of prostate	Y	A2	$345.83	5.6262	$239.36	$319.21
55705	Biopsy of prostate	Y	A2	$345.83	5.6262	$239.36	$319.21
55720	Drainage of prostate abscess	Y	A2	$333.00	23.8700	$1,015.50	$503.63
55725	Drainage of prostate abscess	Y	A2	$446.00	23.8700	$1,015.50	$588.38
55860	Surgical exposure, prostate	Y	G2		18.1679	$772.92	$772.92
55870	Electroejaculation	Y	P3		1.6094	$68.47	$68.47
55873	Cryoablate prostate	Y	H8	$1,339.00	137.5639	$5,852.38	$5,252.74
55875	Transperi needle place, pros	Y	A2	$1,339.00	34.9261	$1,485.86	$1,375.72
55876*	Place rt device/marker, pros	Y	P3		1.6416	$69.84	$69.84
56405	I & D of vulva/perineum	Y	P3		1.0058	$42.79	$42.79
56420	Drainage of gland abscess	Y	P2		1.2900	$54.88	$54.88
56440	Surgery for vulva lesion	Y	A2	$446.00	20.5081	$872.48	$552.62
56441	Lysis of labial lesion(s)	Y	A2	$333.00	14.8489	$631.72	$407.68
56442	Hymenotomy	Y	A2	$333.00	14.8489	$631.72	$407.68
56501	Destroy, vulva lesions, sim	Y	P3		1.3680	$58.20	$58.20
56515	Destroy vulva lesion/s compl	Y	A2	$510.00	20.4276	$869.05	$599.76
56605	Biopsy of vulva/perineum	Y	P3		0.7966	$33.89	$33.89
56606	Biopsy of vulva/perineum	Y	P3		0.3460	$14.72	$14.72
56620	Partial removal of vulva	Y	A2	$717.00	28.5095	$1,212.88	$840.97
56625	Complete removal of vulva	Y	A2	$995.00	28.5095	$1,212.88	$1,049.47
56700	Partial removal of hymen	Y	A2	$333.00	20.5081	$872.48	$467.87
56740	Remove vagina gland lesion	Y	A2	$510.00	20.5081	$872.48	$600.62
56800	Repair of vagina	Y	A2	$510.00	20.5081	$872.48	$600.62
56805	Repair clitoris	Y	G2		14.8489	$631.72	$631.72
56810	Repair of perineum	Y	A2	$717.00	20.5081	$872.48	$755.87
56820	Exam of vulva w/scope	Y	P3		1.0058	$42.79	$42.79
56821	Exam/biopsy of vulva w/scope	Y	P3		1.3116	$55.80	$55.80
57000	Exploration of vagina	Y	A2	$333.00	14.8489	$631.72	$407.68
57010	Drainage of pelvic abscess	Y	A2	$446.00	14.8489	$631.72	$492.43
57020	Drainage of pelvic fluid	Y	A2	$409.33	6.6592	$283.30	$377.82
57022	I & d vaginal hematoma, pp	Y	G2		11.1535	$474.50	$474.50
57023	I & d vag hematoma, non-ob	Y	A2	$333.00	17.5086	$744.87	$435.97
57061	Destroy vag lesions, simple	Y	P3		1.2634	$53.75	$53.75
57065	Destroy vag lesions, complex	Y	A2	$333.00	20.5081	$872.48	$467.87
57100	Biopsy of vagina	Y	P3		0.8048	$34.24	$34.24
57105	Biopsy of vagina	Y	A2	$446.00	20.5081	$872.48	$552.62
57130	Remove vagina lesion	Y	A2	$446.00	20.5081	$872.48	$552.62
57135	Remove vagina lesion	Y	A2	$446.00	20.5081	$872.48	$552.62
57150	Treat vagina infection	Y	P2		0.1468	$6.25	$6.25
57155	Insert uteri tandems/ovoids	Y	A2	$409.33	6.6592	$283.30	$377.82
57160	Insert pessary/other device	Y	P3		0.8208	$34.92	$34.92
57170	Fitting of diaphragm/cap	Y	P2		0.1468	$6.25	$6.25
57180	Treat vaginal bleeding	Y	A2	$178.05	2.8966	$123.23	$164.35
57200	Repair of vagina	Y	A2	$333.00	20.5081	$872.48	$467.87
57210	Repair vagina/perineum	Y	A2	$446.00	20.5081	$872.48	$552.62
57220	Revision of urethra	Y	A2	$510.00	42.9896	$1,828.91	$839.73
57230	Repair of urethral lesion	Y	A2	$510.00	28.5095	$1,212.88	$685.72
57240	Repair bladder & vagina	Y	A2	$717.00	28.5095	$1,212.88	$840.97
57250	Repair rectum & vagina	Y	A2	$717.00	28.5095	$1,212.88	$840.97
57260	Repair of vagina	Y	A2	$717.00	28.5095	$1,212.88	$840.97
57265	Extensive repair of vagina	Y	A2	$995.00	42.9896	$1,828.91	$1,203.48
57267	Insert mesh/pelvic flr addon	Y	A2	$995.00	28.5095	$1,212.88	$1,049.47
57268	Repair of bowel bulge	Y	A2	$510.00	28.5095	$1,212.88	$685.72

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
57287	Revise/remove sling repair	Y	G2		28.5095	$1,212.88	$1,212.88
57288	Repair bladder defect	Y	A2	$717.00	42.9896	$1,828.91	$994.98
57289	Repair bladder & vagina	Y	A2	$717.00	28.5095	$1,212.88	$840.97
57291	Construction of vagina	Y	A2	$717.00	28.5095	$1,212.88	$840.97
57300	Repair rectum-vagina fistula	Y	A2	$510.00	28.5095	$1,212.88	$685.72
57320	Repair bladder-vagina lesion	Y	G2		28.5095	$1,212.88	$1,212.88
57400	Dilation of vagina	Y	A2	$446.00	20.5081	$872.48	$552.62
57410	Pelvic examination	Y	A2	$446.00	14.8489	$631.72	$492.43
57415	Remove vaginal foreign body	Y	A2	$446.00	20.5081	$872.48	$552.62
57420	Exam of vagina w/scope	Y	P3		1.0380	$44.16	$44.16
57421	Exam/biopsy of vag w/scope	Y	P3		1.3842	$58.89	$58.89
57452	Exam of cervix w/scope	Y	P3		0.9818	$41.77	$41.77
57454	Bx/curett of cervix w/scope	Y	P3		1.2232	$52.04	$52.04
57455	Biopsy of cervix w/scope	Y	P3		1.2876	$54.78	$54.78
57456	Endocerv curettage w/scope	Y	P3		1.2474	$53.07	$53.07
57460	Bx of cervix w/scope, leep	Y	P3		4.0639	$172.89	$172.89
57461	Conz of cervix w/scope, leep	Y	P3		4.2811	$182.13	$182.13
57500	Biopsy of cervix	Y	P3		1.8186	$77.37	$77.37
57505	Endocervical curettage	Y	P3		1.1104	$47.24	$47.24
57510	Cauterization of cervix	Y	P3		1.1508	$48.96	$48.96
57511	Cryocautery of cervix	Y	P2		1.2900	$54.88	$54.88
57513	Laser surgery of cervix	Y	A2	$446.00	14.8489	$631.72	$492.43
57520	Conization of cervix	Y	A2	$446.00	20.5081	$872.48	$552.62
57522	Conization of cervix	Y	A2	$446.00	28.5095	$1,212.88	$637.72
57530	Removal of cervix	Y	A2	$510.00	28.5095	$1,212.88	$685.72
57550	Removal of residual cervix	Y	A2	$510.00	28.5095	$1,212.88	$685.72
57556	Remove cervix, repair bowel	Y	A2	$717.00	42.9896	$1,828.91	$994.98
57558	D&c of cervical stump	Y	A2	$510.00	17.7499	$755.13	$571.28
57700	Revision of cervix	Y	A2	$333.00	20.5081	$872.48	$467.87
57720	Revision of cervix	Y	A2	$510.00	20.5081	$872.48	$600.62
57800	Dilation of cervical canal	Y	P3		0.5874	$24.99	$24.99
58100	Biopsy of uterus lining	Y	P3		0.9818	$41.77	$41.77
58110*	Bx done w/colposcopy add-on	Y	P3		0.3782	$16.09	$16.09
58120	Dilation and curettage	Y	A2	$446.00	17.7499	$755.13	$523.28
58145	Myomectomy vag method	Y	A2	$717.00	28.5095	$1,212.88	$840.97
58301	Remove intrauterine device	Y	P3		0.9496	$40.40	$40.40
58321	Artificial insemination	Y	P3		0.8450	$35.95	$35.95
58322	Artificial insemination	Y	P3		0.9012	$38.34	$38.34
58323	Sperm washing	Y	P3		0.2736	$11.64	$11.64
58340	Catheter for hysterography		N1				
58345	Reopen fallopian tube	Y	R2		14.8489	$631.72	$631.72
58346	Insert heyman uteri capsule	Y	A2	$446.00	14.8489	$631.72	$492.43
58350	Reopen fallopian tube	Y	A2	$510.00	28.5095	$1,212.88	$685.72
58353	Endometr ablate, thermal	Y	A2	$995.00	28.5095	$1,212.88	$1,049.47
58356	Endometrial cryoablation	Y	P3		41.9827	$1,786.07	$1,786.07
58545	Laparoscopic myomectomy	Y	A2	$1,339.00	32.1241	$1,366.66	$1,345.92
58546	Laparo-myomectomy, complex	Y	A2	$1,339.00	43.5488	$1,852.70	$1,467.43
58550	Laparo-asst vag hysterectomy	Y	A2	$1,339.00	70.5066	$2,999.56	$1,754.14
58552	Laparo-vag hyst incl t/o	Y	G2		43.5488	$1,852.70	$1,852.70
58555	Hysteroscopy, dx, sep proc	Y	A2	$333.00	21.3586	$908.66	$476.92
58558	Hysteroscopy, biopsy	Y	A2	$510.00	21.3586	$908.66	$609.67
58559	Hysteroscopy, lysis	Y	A2	$446.00	21.3586	$908.66	$561.67
58560	Hysteroscopy, resect septum	Y	A2	$510.00	34.0155	$1,447.12	$744.28
58561	Hysteroscopy, remove myoma	Y	A2	$510.00	34.0155	$1,447.12	$744.28
58562	Hysteroscopy, remove fb	Y	A2	$510.00	21.3586	$908.66	$609.67
58563	Hysteroscopy, ablation	Y	A2	$1,339.00	34.0155	$1,447.12	$1,366.03
58565	Hysteroscopy, sterilization	Y	A2	$1,339.00	42.9896	$1,828.91	$1,461.48
58600	Division of fallopian tube	Y	G2		28.5095	$1,212.88	$1,212.88
58615	Occlude fallopian tube(s)	Y	G2		20.5081	$872.48	$872.48
58660	Laparoscopy, lysis	Y	A2	$717.00	43.5488	$1,852.70	$1,000.93
58661	Laparoscopy, remove adnexa	Y	A2	$717.00	43.5488	$1,852.70	$1,000.93
58662	Laparoscopy, excise lesions	Y	A2	$717.00	43.5488	$1,852.70	$1,000.93
58670	Laparoscopy, tubal cautery	Y	A2	$510.00	43.5488	$1,852.70	$845.68

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
58671	Laparoscopy, tubal block	Y	A2	$510.00	43.5488	$1,852.70	$845.68
58672	Laparoscopy, fimbrioplasty	Y	A2	$717.00	43.5488	$1,852.70	$1,000.93
58673	Laparoscopy, salpingostomy	Y	A2	$717.00	43.5488	$1,852.70	$1,000.93
58800	Drainage of ovarian cyst(s)	Y	A2	$510.00	14.8489	$631.72	$540.43
58820	Drain ovary abscess, open	Y	A2	$510.00	28.5095	$1,212.88	$685.72
58900	Biopsy of ovary(s)	Y	A2	$510.00	14.8489	$631.72	$540.43
58970	Retrieval of oocyte	Y	A2	$245.92	4.0007	$170.20	$226.99
58974	Transfer of embryo	Y	A2	$245.92	4.0007	$170.20	$226.99
58976	Transfer of embryo	Y	A2	$245.92	4.0007	$170.20	$226.99
59000	Amniocentesis, diagnostic	Y	P2	.....	1.4222	$60.50	$60.50
59001	Amniocentesis, therapeutic	Y	R2	.....	6.6592	$283.30	$283.30
59012	Fetal cord puncture, prenatal	Y	G2	.....	1.4222	$60.50	$60.50
59015	Chorion biopsy	Y	P3	.....	1.1910	$50.67	$50.67
59020	Fetal contract stress test	Y	P3	.....	0.5632	$23.96	$23.96
59025	Fetal non-stress test	Y	P3	.....	0.2816	$11.98	$11.98
59070	Transabdom amnioinfus w/us	Y	G2	.....	1.4222	$60.50	$60.50
59072	Umbilical cord occlud w/us	Y	G2	.....	1.4222	$60.50	$60.50
59076	Fetal shunt placement, w/us	Y	G2	.....	1.4222	$60.50	$60.50
59100	Remove uterus lesion	Y	R2	.....	28.5095	$1,212.88	$1,212.88
59150	Treat ectopic pregnancy	Y	G2	.....	43.5488	$1,852.70	$1,852.70
59151	Treat ectopic pregnancy	Y	G2	.....	43.5488	$1,852.70	$1,852.70
59160	D& c after delivery	Y	A2	$510.00	17.7499	$755.13	$571.28
59200	Insert cervical dilator	Y	P3	.....	0.8530	$36.29	$36.29
59300	Episiotomy or vaginal repair	Y	P3	.....	1.7542	$74.63	$74.63
59320	Revision of cervix	Y	A2	$333.00	20.5081	$872.48	$467.87
59412	Antepartum manipulation	Y	G2	.....	2.3864	$101.52	$101.52
59414	Deliver placenta	Y	G2	.....	14.8489	$631.72	$631.72
59812	Treatment of miscarriage	Y	A2	$717.00	18.5201	$787.90	$734.73
59820	Care of miscarriage	Y	A2	$717.00	18.5201	$787.90	$734.73
59821	Treatment of miscarriage	Y	A2	$717.00	18.5201	$787.90	$734.73
59840	Abortion	Y	A2	$717.00	16.9328	$720.37	$717.84
59841	Abortion	Y	A2	$717.00	16.9328	$720.37	$717.84
59866	Abortion (mpr)	Y	G2	.....	1.4222	$60.50	$60.50
59870	Evacuate mole of uterus	Y	A2	$717.00	18.5201	$787.90	$734.73
59871	Remove cerclage suture	Y	A2	$717.00	20.5081	$872.48	$755.87
60000	Drain thyroid/tongue cyst	Y	A2	$333.00	7.5511	$321.25	$330.06
60001	Aspirate/inject thyriod cyst	Y	P3	.....	1.3116	$55.80	$55.80
60100	Biopsy of thyroid	Y	P3	.....	1.0462	$44.51	$44.51
60200	Remove thyroid lesion	Y	A2	$446.00	37.7224	$1,604.82	$735.71
60280	Remove thyroid duct lesion	Y	A2	$630.00	37.7224	$1,604.82	$873.71
60281	Remove thyroid duct lesion	Y	A2	$630.00	37.7224	$1,604.82	$873.71
61000	Remove cranial cavity fluid	Y	R2	.....	2.9907	$127.23	$127.23
61001	Remove cranial cavity fluid	Y	R2	.....	2.9907	$127.23	$127.23
61020	Remove brain cavity fluid	Y	A2	$183.83	2.9907	$127.23	$169.68
61026	Injection into brain canal	Y	A2	$183.83	2.9907	$127.23	$169.68
61050	Remove brain canal fluid	Y	A2	$183.83	2.9907	$127.23	$169.68
61055	Injection into brain canal	Y	A2	$183.83	2.9907	$127.23	$169.68
61070	Brain canal shunt procedure	Y	A2	$183.83	2.9907	$127.23	$169.68
61215	Insert brain-fluid device	Y	A2	$510.00	47.0342	$2,000.98	$882.75
61330	Decompress eye socket	Y	G2	.....	38.1991	$1,625.10	$1,625.10
61334	Explore orbit/remove object	Y	G2	.....	38.1991	$1,625.10	$1,625.10
61790	Treat trigeminal nerve	Y	A2	$510.00	17.8499	$759.39	$572.35
61791	Treat trigeminal tract	Y	A2	$351.92	5.7253	$243.57	$324.83
61795	Brain surgery using computer	N	A2	$302.04	4.9138	$209.05	$278.79
61880	Revise/remove neuroelectrode	Y	G2	.....	17.8334	$758.69	$758.69
61885	Insrt/redo neurostim 1 array	N	H8	$446.00	260.1530	$11,067.69	$10,137.66
61886	Implant neurostim arrays	Y	H8	$510.00	342.4747	$14,569.90	$13,649.39
61888	Revise/remove neuroreceiver	Y	A2	$333.00	35.5702	$1,513.26	$628.07
62194	Replace/irrigate catheter	Y	A2	$333.00	11.6575	$495.95	$373.74
62225	Replace/irrigate catheter	Y	A2	$333.00	11.6575	$495.95	$373.74
62230	Replace/revise brain shunt	Y	A2	$446.00	47.0342	$2,000.98	$834.75
62252	Csf shunt reprogram	N	P3	.....	1.0462	$44.51	$44.51
62263	Epidural lysis mult sessions	Y	A2	$333.00	12.1702	$517.76	$379.19

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
62264	Epidural lysis on single day	Y	A2	$333.00	12.1702	$517.76	$379.19
62268	Drain spinal cord cyst	Y	A2	$183.83	2.9907	$127.23	$169.68
62269	Needle biopsy, spinal cord	Y	A2	$333.00	6.1384	$261.15	$315.04
62270	Spinal fluid tap, diagnostic	Y	A2	$139.00	2.2614	$96.21	$128.30
62272	Drain cerebro spinal fluid	Y	A2	$139.00	2.2614	$96.21	$128.30
62273	Inject epidural patch	Y	A2	$333.00	5.7253	$243.57	$310.64
62280	Treat spinal cord lesion	Y	A2	$333.00	6.3603	$270.59	$317.40
62281	Treat spinal cord lesion	Y	A2	$333.00	6.3603	$270.59	$317.40
62282	Treat spinal canal lesion	Y	A2	$333.00	6.3603	$270.59	$317.40
62284	Injection for myelogram		N1				
62287	Percutaneous diskectomy	Y	A2	$1,339.00	33.1520	$1,410.39	$1,356.85
62290	Inject for spine disk x-ray		N1				
62291	Inject for spine disk x-ray		N1				
62292	Injection into disk lesion	Y	G2		2.9907	$127.23	$127.23
62294	Injection into spinal artery	Y	A2	$183.83	2.9907	$127.23	$169.68
62310	Inject spine c/t	Y	A2	$333.00	6.3603	$270.59	$317.40
62311	Inject spine l/s (cd)	Y	A2	$333.00	6.3603	$270.59	$317.40
62318	Inject spine w/cath, c/t	Y	A2	$333.00	6.3603	$270.59	$317.40
62319	Inject spine w/cath l/s (cd)	Y	A2	$333.00	6.3603	$270.59	$317.40
62350	Implant spinal canal cath	Y	A2	$446.00	30.8394	$1,312.00	$662.50
62355	Remove spinal canal catheter	Y	A2	$446.00	12.1702	$517.76	$463.94
62360	Insert spine infusion device	Y	A2	$446.00	112.6322	$4,791.71	$1,532.43
62361	Implant spine infusion pump	Y	H8	$446.00	243.3568	$10,353.13	$9,589.69
62362	Implant spine infusion pump	Y	H8	$446.00	243.3568	$10,353.13	$9,589.69
62365	Remove spine infusion device	Y	A2	$446.00	33.1520	$1,410.39	$687.10
62367	Analyze spine infusion pump	N	P3		0.4104	$17.46	$17.46
62368	Analyze spine infusion pump	N	P3		0.5150	$21.91	$21.91
63600	Remove spinal cord lesion	Y	A2	$446.00	17.8499	$759.39	$524.35
63610	Stimulation of spinal cord	Y	A2	$333.00	17.8499	$759.39	$439.60
63615	Remove lesion of spinal cord	Y	R2		17.8499	$759.39	$759.39
63650	Implant neuroelectrodes	N	H8	$446.00	71.6329	$3,047.48	$2,552.76
63655	Implant neuroelectrodes	N	J8		109.1028	$4,641.56	$4,641.56
63660	Revise/remove neuroelectrode	Y	A2	$333.00	17.8334	$758.69	$439.42
63685	Insrt/redo spine n generator	Y	H8	$446.00	251.0862	$10,681.96	$9,721.25
63688	Revise/remove neuroreceiver	Y	A2	$333.00	35.5702	$1,513.26	$628.07
63744	Revision of spinal shunt	Y	A2	$510.00	39.2633	$1,670.38	$800.10
63746	Removal of spinal shunt	Y	A2	$446.00	10.9918	$467.62	$451.41
64400	Nblock inj, trigeminal	Y	P3		1.3198	$56.15	$56.15
64402	Nblock inj, facial	Y	P3		1.2312	$52.38	$52.38
64405	Nblock inj, occipital	Y	P3		1.0542	$44.85	$44.85
64408	Nblock inj, vagus	Y	P3		1.2232	$52.04	$52.04
64410	Nblock inj, phrenic	Y	A2	$333.00	5.7253	$243.57	$310.64
64412	Nblock inj, spinal accessor	Y	P3		1.8830	$80.11	$80.11
64413	Nblock inj, cervical plexus	Y	P3		1.2554	$53.41	$53.41
64415	Nblock inj, brachial plexus	Y	A2	$139.00	2.2614	$96.21	$128.30
64416	Nblock cont infuse, b plex	Y	G2		2.2614	$96.21	$96.21
64417	Nblock inj, axillary	Y	A2	$139.00	2.2614	$96.21	$128.30
64418	Nblock inj, suprascapular	Y	P3		1.8026	$76.69	$76.69
64420	Nblock inj, intercost, sng	Y	A2	$139.00	2.2614	$96.21	$128.30
64421	Nblock inj, intercost, mlt	Y	A2	$333.00	5.7253	$243.57	$310.64
64425	Nblock inj, ilio-ing/hypogi	Y	P3		1.1990	$51.01	$51.01
64430	Nblock inj, pudendal	Y	A2	$139.00	2.2614	$96.21	$128.30
64435	Nblock inj, paracervical	Y	P3		1.8026	$76.69	$76.69
64445	Nblock inj, sciatic, sng	Y	P3		1.7382	$73.95	$73.95
64446	Nblk inj, sciatic, cont inf	Y	G2		5.7253	$243.57	$243.57
64447	Nblock inj fem, single	Y	G2		2.2614	$96.21	$96.21
64450	Nblock, other peripheral	Y	P3		1.0140	$43.14	$43.14
64470	Inj paravertebral c/t	Y	A2	$333.00	6.3603	$270.59	$317.40
64472	Inj paravertebral c/t add-on	Y	A2	$333.00	5.7253	$243.57	$310.64
64475	Inj paravertebral l/s	Y	A2	$333.00	6.3603	$270.59	$317.40
64476	Inj paravertebral l/s add-on	Y	A2	$333.00	5.7253	$243.57	$310.64
64479	Inj foramen epidural c/t	Y	A2	$333.00	6.3603	$270.59	$317.40
64480	Inj foramen epidural add-on	Y	A2	$333.00	6.3603	$270.59	$317.40

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
64483	Inj foramen epidural l/s	Y	A2	$333.00	6.3603	$270.59	$317.40
64484	Inj foramen epidural add-on	Y	A2	$333.00	6.3603	$270.59	$317.40
64505	Nblock, spenopalatine gangl	Y	P3		0.9416	$40.06	$40.06
64508	Nblock, carotid sinus s/p	Y	P3		2.0922	$89.01	$89.01
64510	Nblock, stellate ganglion	Y	A2	$333.00	6.3603	$270.59	$317.40
64517	Nblock inj, hypogas plxs	Y	A2	$139.00	2.2614	$96.21	$128.30
64520	Nblock, lumbar/thoracic	Y	A2	$333.00	6.3603	$270.59	$317.40
64530	Nblock inj, celiac pelus	Y	A2	$333.00	6.3603	$270.59	$317.40
64553	Implant neuroelectrodes	N	H8	$333.00	307.2433	$13,071.05	$11,841.79
64555	Implant neuroelectrodes	N	J8		71.6329	$3,047.48	$3,047.48
64560	Implant neuroelectrodes	N	J8		71.6329	$3,047.48	$3,047.48
64561	Implant neuroelectrodes	N	H8	$510.00	71.6329	$3,047.48	$2,600.76
64565	Implant neuroelectrodes	N	J8		71.6329	$3,047.48	$3,047.48
64573	Implant neuroelectrodes	N	H8	$333.00	307.2433	$13,071.05	$11,841.79
64575	Implant neuroelectrodes	N	H8	$333.00	109.1028	$4,641.56	$3,818.33
64577	Implant neuroelectrodes	N	H8	$333.00	109.1028	$4,641.56	$3,818.33
64580	Implant neuroelectrodes	N	H8	$333.00	109.1028	$4,641.56	$3,818.33
64581	Implant neuroelectrodes	N	H8	$510.00	109.1028	$4,641.56	$3,951.08
64585	Revise/remove neuroelectrode	Y	A2	$333.00	17.8334	$758.69	$439.42
64590	Insrt/redo pn/gastr stimul	Y	H8	$446.00	251.0862	$10,681.96	$9,721.25
64595	Revise/rmv pn/gastr stimul	Y	A2	$333.00	35.5702	$1,513.26	$628.07
64600	Injection treatment of nerve	Y	A2	$333.00	12.1702	$517.76	$379.19
64605	Injection treatment of nerve	Y	A2	$333.00	12.1702	$517.76	$379.19
64610	Injection treatment of nerve	Y	A2	$333.00	12.1702	$517.76	$379.19
64612	Destroy nerve, face muscle	Y	P3		1.6579	$70.53	$70.53
64613	Destroy nerve, neck muscle	Y	P3		1.7302	$73.61	$73.61
64614	Destroy nerve, extrem musc	Y	P3		1.9474	$82.85	$82.85
64620	Injection treatment of nerve	Y	A2	$333.00	12.1702	$517.76	$379.19
64622	Destr paravertebrl nerve l/s	Y	A2	$333.00	12.1702	$517.76	$379.19
64623	Destr paravertebral n add-on	Y	A2	$333.00	6.3603	$270.59	$317.40
64626	Destr paravertebrl nerve c/t	Y	A2	$333.00	12.1702	$517.76	$379.19
64627	Destr paravertebral n add-on	Y	A2	$333.00	6.3603	$270.59	$317.40
64630	Injection treatment of nerve	Y	A2	$351.92	5.7253	$243.57	$324.83
64640	Injection treatment of nerve	Y	P3		2.6716	$113.66	$113.66
64650	Chemodenerv eccrine glands	Y	G2		2.2614	$96.21	$96.21
64653	Chemodenerv eccrine glands	Y	G2		2.2614	$96.21	$96.21
64680	Injection treatment of nerve	Y	A2	$390.95	6.3603	$270.59	$360.86
64681	Injection treatment of nerve	Y	A2	$446.00	12.1702	$517.76	$463.94
64702	Revise finger/toe nerve	Y	A2	$333.00	17.8499	$759.39	$439.60
64704	Revise hand/foot nerve	Y	A2	$333.00	17.8499	$759.39	$439.60
64708	Revise arm/leg nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64712	Revision of sciatic nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64713	Revision of arm nerve(s)	Y	A2	$446.00	17.8499	$759.39	$524.35
64714	Revise low back nerve(s)	Y	A2	$446.00	17.8499	$759.39	$524.35
64716	Revision of cranial nerve	Y	A2	$510.00	17.8499	$759.39	$572.35
64718	Revise ulnar nerve at elbow	Y	A2	$446.00	17.8499	$759.39	$524.35
64719	Revise ulnar nerve at wrist	Y	A2	$446.00	17.8499	$759.39	$524.35
64721	Carpal tunnel surgery	Y	A2	$446.00	17.8499	$759.39	$524.35
64722	Relieve pressure on nerve(s)	Y	A2	$333.00	17.8499	$759.39	$439.60
64726	Release foot/toe nerve	Y	A2	$333.00	17.8499	$759.39	$439.60
64727	Internal nerve revision	Y	A2	$333.00	17.8499	$759.39	$439.60
64732	Incision of brow nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64734	Incision of cheek nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64736	Incision of chin nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64738	Incision of jaw nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64740	Incision of tongue nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64742	Incision of facial nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64744	Incise nerve, back of head	Y	A2	$446.00	17.8499	$759.39	$524.35
64746	Incise diaphragm nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64761	Incision of pelvis nerve	Y	G2		17.8499	$759.39	$759.39
64763	Incise hip/thigh nerve	Y	G2		17.8499	$759.39	$759.39
64766	Incise hip/thigh nerve	Y	G2		33.1520	$1,410.39	$1,410.39
64771	Sever cranial nerve	Y	A2	$446.00	17.8499	$759.39	$524.35

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
64772	Incision of spinal nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64774	Remove skin nerve lesion	Y	A2	$446.00	17.8499	$759.39	$524.35
64776	Remove digit nerve lesion	Y	A2	$510.00	17.8499	$759.39	$572.35
64778	Digit nerve surgery add-on	Y	A2	$446.00	17.8499	$759.39	$524.35
64782	Remove limb nerve lesion	Y	A2	$510.00	17.8499	$759.39	$572.35
64783	Limb nerve surgery add-on	Y	A2	$446.00	17.8499	$759.39	$524.35
64784	Remove nerve lesion	Y	A2	$510.00	17.8499	$759.39	$572.35
64786	Remove sciatic nerve lesion	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64787	Implant nerve end	Y	A2	$446.00	17.8499	$759.39	$524.35
64788	Remove skin nerve lesion	Y	A2	$510.00	17.8499	$759.39	$572.35
64790	Removal of nerve lesion	Y	A2	$510.00	17.8499	$759.39	$572.35
64792	Removal of nerve lesion	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64795	Biopsy of nerve	Y	A2	$446.00	17.8499	$759.39	$524.35
64802	Remove sympathetic nerves	Y	A2	$446.00	17.8499	$759.39	$524.35
64820	Remove sympathetic nerves	Y	G2	.....	17.8499	$759.39	$759.39
64821	Remove sympathetic nerves	Y	A2	$630.00	25.8758	$1,100.83	$747.71
64822	Remove sympathetic nerves	Y	G2	.....	25.8758	$1,100.83	$1,100.83
64823	Remove sympathetic nerves	Y	G2	.....	25.8758	$1,100.83	$1,100.83
64831	Repair of digit nerve	Y	A2	$630.00	33.1520	$1,410.39	$825.10
64832	Repair nerve add-on	Y	A2	$333.00	33.1520	$1,410.39	$602.35
64834	Repair of hand or foot nerve	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64835	Repair of hand or foot nerve	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64836	Repair of hand or foot nerve	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64837	Repair nerve add-on	Y	A2	$333.00	33.1520	$1,410.39	$602.35
64840	Repair of leg nerve	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64856	Repair/transpose nerve	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64857	Repair arm/leg nerve	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64858	Repair sciatic nerve	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64859	Nerve surgery	Y	A2	$333.00	33.1520	$1,410.39	$602.35
64861	Repair of arm nerves	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64862	Repair of low back nerves	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64864	Repair of facial nerve	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64865	Repair of facial nerve	Y	A2	$630.00	33.1520	$1,410.39	$825.10
64870	Fusion of facial/other nerve	Y	A2	$630.00	33.1520	$1,410.39	$825.10
64872	Subsequent repair of nerve	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64874	Repair & revise nerve add-on	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64876	Repair nerve/shorten bone	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64885	Nerve graft, head or neck	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64886	Nerve graft, head or neck	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64890	Nerve graft, hand or foot	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64891	Nerve graft, hand or foot	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64892	Nerve graft, arm or leg	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64893	Nerve graft, arm or leg	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64895	Nerve graft, hand or foot	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64896	Nerve graft, hand or foot	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64897	Nerve graft, arm or leg	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64898	Nerve graft, arm or leg	Y	A2	$510.00	33.1520	$1,410.39	$735.10
64901	Nerve graft add-on	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64902	Nerve graft add-on	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64905	Nerve pedicle transfer	Y	A2	$446.00	33.1520	$1,410.39	$687.10
64907	Nerve pedicle transfer	Y	A2	$333.00	33.1520	$1,410.39	$602.35
65091	Revise eye	Y	A2	$510.00	35.2292	$1,498.76	$757.19
65093	Revise eye with implant	Y	A2	$510.00	35.2292	$1,498.76	$757.19
65101	Removal of eye	Y	A2	$510.00	35.2292	$1,498.76	$757.19
65103	Remove eye/insert implant	Y	A2	$510.00	35.2292	$1,498.76	$757.19
65105	Remove eye/attach implant	Y	A2	$630.00	35.2292	$1,498.76	$847.19
65110	Removal of eye	Y	A2	$717.00	35.2292	$1,498.76	$912.44
65112	Remove eye/revise socket	Y	A2	$995.00	35.2292	$1,498.76	$1,120.94
65114	Remove eye/revise socket	Y	A2	$995.00	35.2292	$1,498.76	$1,120.94
65125	Revise ocular implant	Y	G2	.....	17.1243	$728.52	$728.52
65130	Insert ocular implant	Y	A2	$510.00	25.2550	$1,074.42	$651.11
65135	Insert ocular implant	Y	A2	$446.00	25.2550	$1,074.42	$603.11
65140	Attach ocular implant	Y	A2	$510.00	35.2292	$1,498.76	$757.19

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
65150	Revise ocular implant	Y	A2	$446.00	25.2550	$1,074.42	$603.11
65155	Reinsert ocular implant	Y	A2	$510.00	35.2292	$1,498.76	$757.19
65175	Removal of ocular implant	Y	A2	$333.00	17.1243	$728.52	$431.88
65205	Remove foreign body from eye	N	P3	.....	0.4990	$21.23	$21.23
65210	Remove foreign body from eye	N	P3	.....	0.6196	$26.36	$26.36
65220	Remove foreign body from eye	N	G2	.....	1.1607	$49.38	$49.38
65222	Remove foreign body from eye	N	P3	.....	0.6840	$29.10	$29.10
65235	Remove foreign body from eye	Y	A2	$446.00	15.2259	$647.76	$496.44
65260	Remove foreign body from eye	Y	A2	$510.00	16.5239	$702.98	$558.25
65265	Remove foreign body from eye	Y	A2	$630.00	27.6020	$1,174.27	$766.07
65270	Repair of eye wound	Y	A2	$446.00	17.1243	$728.52	$516.63
65272	Repair of eye wound	Y	A2	$446.00	22.9970	$978.36	$579.09
65275	Repair of eye wound	Y	A2	$630.00	22.9970	$978.36	$717.09
65280	Repair of eye wound	Y	A2	$630.00	16.5239	$702.98	$648.25
65285	Repair of eye wound	Y	A2	$630.00	37.4290	$1,592.34	$870.59
65286	Repair of eye wound	Y	P2	.....	6.0673	$258.12	$258.12
65290	Repair of eye socket wound	Y	A2	$510.00	21.2801	$905.32	$608.83
65400	Removal of eye lesion	Y	A2	$333.00	15.2259	$647.76	$411.69
65410	Biopsy of cornea	Y	A2	$446.00	15.2259	$647.76	$496.44
65420	Removal of eye lesion	Y	A2	$446.00	15.2259	$647.76	$496.44
65426	Removal of eye lesion	Y	A2	$717.00	22.9970	$978.36	$782.34
65430	Corneal smear	N	P3	.....	0.9736	$41.42	$41.42
65435	Curette/treat cornea	Y	P3	.....	0.7564	$32.18	$32.18
65436	Curette/treat cornea	Y	G2	.....	15.2259	$647.76	$647.76
65450	Treatment of corneal lesion	N	G2	.....	2.1451	$91.26	$91.26
65600	Revision of cornea	Y	P3	.....	3.8707	$164.67	$164.67
65710	Corneal transplant	Y	A2	$995.00	38.2707	$1,628.15	$1,153.29
65730	Corneal transplant	Y	A2	$995.00	38.2707	$1,628.15	$1,153.29
65750	Corneal transplant	Y	A2	$995.00	38.2707	$1,628.15	$1,153.29
65755	Corneal transplant	Y	A2	$995.00	38.2707	$1,628.15	$1,153.29
65770	Revise cornea with implant	Y	A2	$995.00	51.9894	$2,211.78	$1,299.20
65772	Correction of astigmatism	Y	A2	$630.00	15.2259	$647.76	$634.44
65775	Correction of astigmatism	Y	A2	$630.00	15.2259	$647.76	$634.44
65780	Ocular reconst, transplant	Y	A2	$717.00	38.2707	$1,628.15	$944.79
65781	Ocular reconst, transplant	Y	A2	$717.00	38.2707	$1,628.15	$944.79
65782	Ocular reconst, transplant	Y	A2	$717.00	38.2707	$1,628.15	$944.79
65800	Drainage of eye	Y	A2	$333.00	15.2259	$647.76	$411.69
65805	Drainage of eye	Y	A2	$333.00	15.2259	$647.76	$411.69
65810	Drainage of eye	Y	A2	$510.00	22.9970	$978.36	$627.09
65815	Drainage of eye	Y	A2	$446.00	22.9970	$978.36	$579.09
65820	Relieve inner eye pressure	Y	A2	$333.00	6.0673	$258.12	$314.28
65850	Incision of eye	Y	A2	$630.00	22.9970	$978.36	$717.09
65855	Laser surgery of eye	Y	P3	.....	3.1947	$135.91	$135.91
65860	Incise inner eye adhesions	Y	P3	.....	2.9855	$127.01	$127.01
65865	Incise inner eye adhesions	Y	A2	$333.00	15.2259	$647.76	$411.69
65870	Incise inner eye adhesions	Y	A2	$630.00	22.9970	$978.36	$717.09
65875	Incise inner eye adhesions	Y	A2	$630.00	22.9970	$978.36	$717.09
65880	Incise inner eye adhesions	Y	A2	$630.00	15.2259	$647.76	$634.44
65900	Remove eye lesion	Y	A2	$717.00	15.2259	$647.76	$699.69
65920	Remove implant of eye	Y	A2	$995.00	22.9970	$978.36	$990.84
65930	Remove blood clot from eye	Y	A2	$717.00	22.9970	$978.36	$782.34
66020	Injection treatment of eye	Y	A2	$333.00	15.2259	$647.76	$411.69
66030	Injection treatment of eye	Y	A2	$333.00	6.0673	$258.12	$314.28
66130	Remove eye lesion	Y	A2	$995.00	22.9970	$978.36	$990.84
66150	Glaucoma surgery	Y	A2	$630.00	22.9970	$978.36	$717.09
66155	Glaucoma surgery	Y	A2	$630.00	22.9970	$978.36	$717.09
66160	Glaucoma surgery	Y	A2	$446.00	22.9970	$978.36	$579.09
66165	Glaucoma surgery	Y	A2	$630.00	22.9970	$978.36	$717.09
66170	Glaucoma surgery	Y	A2	$630.00	22.9970	$978.36	$717.09
66172	Incision of eye	Y	A2	$630.00	22.9970	$978.36	$717.09
66180	Implant eye shunt	Y	A2	$717.00	37.8967	$1,612.24	$940.81
66185	Revise eye shunt	Y	A2	$446.00	37.8967	$1,612.24	$737.56
66220	Repair eye lesion	Y	A2	$510.00	37.4290	$1,592.34	$780.59

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
66225	Repair/graft eye lesion	Y	A2	$630.00	37.8967	$1,612.24	$875.56
66250	Follow-up surgery of eye	Y	A2	$446.00	15.2259	$647.76	$496.44
66500	Incision of iris	Y	A2	$333.00	6.0673	$258.12	$314.28
66505	Incision of iris	Y	A2	$333.00	6.0673	$258.12	$314.28
66600	Remove iris and lesion	Y	A2	$510.00	22.9970	$978.36	$627.09
66605	Removal of iris	Y	A2	$510.00	22.9970	$978.36	$627.09
66625	Removal of iris	Y	A2	$372.94	6.0673	$258.12	$344.24
66630	Removal of iris	Y	A2	$510.00	22.9970	$978.36	$627.09
66635	Removal of iris	Y	A2	$510.00	22.9970	$978.36	$627.09
66680	Repair iris & ciliary body	Y	A2	$510.00	22.9970	$978.36	$627.09
66682	Repair iris & ciliary body	Y	A2	$446.00	22.9970	$978.36	$579.09
66700	Destruction, ciliary body	Y	A2	$446.00	15.2259	$647.76	$496.44
66710	Ciliary transscleral therapy	Y	A2	$446.00	15.2259	$647.76	$496.44
66711	Ciliary endoscopic ablation	Y	A2	$446.00	15.2259	$647.76	$496.44
66720	Destruction, ciliary body	Y	A2	$446.00	15.2259	$647.76	$496.44
66740	Destruction, ciliary body	Y	A2	$446.00	22.9970	$978.36	$579.09
66761	Revision of iris	Y	P3	.....	4.3375	$184.53	$184.53
66762	Revision of iris	Y	P3	.....	4.4019	$187.27	$187.27
66770	Removal of inner eye lesion	Y	P3	.....	4.7639	$202.67	$202.67
66820	Incision, secondary cataract	Y	G2	.....	6.0673	$258.12	$258.12
66821	After cataract laser surgery	Y	A2	$312.50	5.0839	$216.28	$288.45
66825	Reposition intraocular lens	Y	A2	$630.00	22.9970	$978.36	$717.09
66830	Removal of lens lesion	Y	A2	$372.94	6.0673	$258.12	$344.24
66840	Removal of lens material	Y	A2	$630.00	14.8702	$632.62	$630.66
66850	Removal of lens material	Y	A2	$995.00	29.2281	$1,243.45	$1,057.11
66852	Removal of lens material	Y	A2	$630.00	29.2281	$1,243.45	$783.36
66920	Extraction of lens	Y	A2	$630.00	29.2281	$1,243.45	$783.36
66930	Extraction of lens	Y	A2	$717.00	29.2281	$1,243.45	$848.61
66940	Extraction of lens	Y	A2	$717.00	14.8702	$632.62	$695.91
66982	Cataract surgery, complex	Y	A2	$973.00	23.6313	$1,005.35	$981.09
66983	Cataract surg w/iol, 1 stage	Y	A2	$973.00	23.6313	$1,005.35	$981.09
66984	Cataract surg w/iol, 1 stage	Y	A2	$973.00	23.6313	$1,005.35	$981.09
66985	Insert lens prosthesis	Y	A2	$826.00	23.6313	$1,005.35	$870.84
66986	Exchange lens prosthesis	Y	A2	$826.00	23.6313	$1,005.35	$870.84
66990	Ophthalmic endoscope add-on	.....	N1	.....	.....	.....	.....
67005	Partial removal of eye fluid	Y	A2	$630.00	27.6020	$1,174.27	$766.07
67010	Partial removal of eye fluid	Y	A2	$630.00	27.6020	$1,174.27	$766.07
67015	Release of eye fluid	Y	A2	$333.00	27.6020	$1,174.27	$543.32
67025	Replace eye fluid	Y	A2	$333.00	27.6020	$1,174.27	$543.32
67027	Implant eye drug system	Y	A2	$630.00	37.4290	$1,592.34	$870.59
67028	Injection eye drug	Y	P3	.....	1.9876	$84.56	$84.56
67030	Incise inner eye strands	Y	A2	$333.00	16.5239	$702.98	$425.50
67031	Laser surgery, eye strands	Y	A2	$312.50	5.0839	$216.28	$288.45
67036	Removal of inner eye fluid	Y	A2	$630.00	37.4290	$1,592.34	$870.59
67038	Strip retinal membrane	Y	A2	$717.00	37.4290	$1,592.34	$935.84
67039	Laser treatment of retina	Y	A2	$995.00	37.4290	$1,592.34	$1,144.34
67040	Laser treatment of retina	Y	A2	$995.00	37.4290	$1,592.34	$1,144.34
67101	Repair detached retina	Y	P3	.....	7.2104	$306.75	$306.75
67105	Repair detached retina	Y	P2	.....	5.0841	$216.29	$216.29
67107	Repair detached retina	Y	A2	$717.00	37.4290	$1,592.34	$935.84
67108	Repair detached retina	Y	A2	$995.00	37.4290	$1,592.34	$1,144.34
67110	Repair detached retina	Y	P3	.....	7.8462	$333.80	$333.80
67112	Rerepair detached retina	Y	A2	$995.00	37.4290	$1,592.34	$1,144.34
67115	Release encircling material	Y	A2	$446.00	16.5239	$702.98	$510.25
67120	Remove eye implant material	Y	A2	$446.00	16.5239	$702.98	$510.25
67121	Remove eye implant material	Y	A2	$446.00	27.6020	$1,174.27	$628.07
67141	Treatment of retina	Y	A2	$241.77	3.9333	$167.33	$223.16
67145	Treatment of retina	Y	P3	.....	4.5387	$193.09	$193.09
67208	Treatment of retinal lesion	Y	P3	.....	4.8283	$205.41	$205.41
67210	Treatment of retinal lesion	Y	P2	.....	5.0841	$216.29	$216.29
67218	Treatment of retinal lesion	Y	A2	$717.00	16.5239	$702.98	$713.50
67220	Treatment of choroid lesion	Y	P2	.....	3.9333	$167.33	$167.33
67221	Ocular photodynamic ther	Y	P3	.....	2.9695	$126.33	$126.33

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
67225	Eye photodynamic ther add-on	Y	P3		0.2012	$8.56	$8.56
67227	Treatment of retinal lesion	Y	A2	$333.00	27.6020	$1,174.27	$543.32
67228	Treatment of retinal lesion	Y	P2		5.0841	$216.29	$216.29
67250	Reinforce eye wall	Y	A2	$510.00	17.1243	$728.52	$564.63
67255	Reinforce/graft eye wall	Y	A2	$510.00	27.6020	$1,174.27	$676.07
67311	Revise eye muscle	Y	A2	$510.00	21.2801	$905.32	$608.83
67312	Revise two eye muscles	Y	A2	$630.00	21.2801	$905.32	$698.83
67314	Revise eye muscle	Y	A2	$630.00	21.2801	$905.32	$698.83
67316	Revise two eye muscles	Y	A2	$630.00	21.2801	$905.32	$698.83
67318	Revise eye muscle(s)	Y	A2	$630.00	21.2801	$905.32	$698.83
67320	Revise eye muscle(s) add-on	Y	A2	$630.00	21.2801	$905.32	$698.83
67331	Eye surgery follow-up add-on	Y	A2	$630.00	21.2801	$905.32	$698.83
67332	Rerevise eye muscles add-on	Y	A2	$630.00	21.2801	$905.32	$698.83
67334	Revise eye muscle w/suture	Y	A2	$630.00	21.2801	$905.32	$698.83
67335	Eye suture during surgery	Y	A2	$630.00	21.2801	$905.32	$698.83
67340	Revise eye muscle add-on	Y	A2	$630.00	21.2801	$905.32	$698.83
67343	Release eye tissue	Y	A2	$995.00	21.2801	$905.32	$972.58
67345	Destroy nerve of eye muscle	Y	P3		1.9634	$83.53	$83.53
67346	Biopsy, eye muscle	Y	A2	$333.00	14.3845	$611.96	$402.74
67400	Explore/biopsy eye socket	Y	A2	$510.00	25.2550	$1,074.42	$651.11
67405	Explore/drain eye socket	Y	A2	$630.00	25.2550	$1,074.42	$741.11
67412	Explore/treat eye socket	Y	A2	$717.00	25.2550	$1,074.42	$806.36
67413	Explore/treat eye socket	Y	A2	$717.00	25.2550	$1,074.42	$806.36
67414	Explr/decompress eye socket	Y	G2		35.2292	$1,498.76	$1,498.76
67415	Aspiration, orbital contents	Y	A2	$333.00	17.1243	$728.52	$431.88
67420	Explore/treat eye socket	Y	A2	$717.00	35.2292	$1,498.76	$912.44
67430	Explore/treat eye socket	Y	A2	$717.00	35.2292	$1,498.76	$912.44
67440	Explore/drain eye socket	Y	A2	$717.00	35.2292	$1,498.76	$912.44
67445	Explr/decompress eye socket	Y	A2	$717.00	35.2292	$1,498.76	$912.44
67450	Explore/biopsy eye socket	Y	A2	$717.00	35.2292	$1,498.76	$912.44
67500	Inject/treat eye socket	N	G2		2.1451	$91.26	$91.26
67505	Inject/treat eye socket	Y	G2		2.8954	$123.18	$123.18
67515	Inject/treat eye socket	Y	P3		0.5714	$24.31	$24.31
67550	Insert eye socket implant	Y	A2	$630.00	35.2292	$1,498.76	$847.19
67560	Revise eye socket implant	Y	A2	$446.00	25.2550	$1,074.42	$603.11
67570	Decompress optic nerve	Y	A2	$630.00	35.2292	$1,498.76	$847.19
67700	Drainage of eyelid abscess	Y	P2		2.8954	$123.18	$123.18
67710	Incision of eyelid	Y	P3		3.6777	$156.46	$156.46
67715	Incision of eyelid fold	Y	A2	$333.00	17.1243	$728.52	$431.88
67800	Remove eyelid lesion	Y	P3		1.2312	$52.38	$52.38
67801	Remove eyelid lesions	Y	P3		1.4888	$63.34	$63.34
67805	Remove eyelid lesions	Y	P3		1.9232	$81.82	$81.82
67808	Remove eyelid lesion(s)	Y	A2	$446.00	17.1243	$728.52	$516.63
67810	Biopsy of eyelid	Y	P2		2.8954	$123.18	$123.18
67820	Revise eyelashes	N	P3		0.4264	$18.14	$18.14
67825	Revise eyelashes	Y	P3		1.2794	$54.43	$54.43
67830	Revise eyelashes	Y	A2	$446.00	7.2819	$309.79	$411.95
67835	Revise eyelashes	Y	A2	$446.00	17.1243	$728.52	$516.63
67840	Remove eyelid lesion	Y	P3		3.8063	$161.93	$161.93
67850	Treat eyelid lesion	Y	P3		2.6879	$114.35	$114.35
67875	Closure of eyelid by suture	Y	G2		7.2819	$309.79	$309.79
67880	Revision of eyelid	Y	A2	$510.00	15.2259	$647.76	$544.44
67882	Revision of eyelid	Y	A2	$510.00	17.1243	$728.52	$564.63
67900	Repair brow defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67901	Repair eyelid defect	Y	A2	$717.00	17.1243	$728.52	$719.88
67902	Repair eyelid defect	Y	A2	$717.00	17.1243	$728.52	$719.88
67903	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67904	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67906	Repair eyelid defect	Y	A2	$717.00	17.1243	$728.52	$719.88
67908	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67909	Revise eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67911	Revise eyelid defect	Y	A2	$510.00	17.1243	$728.52	$564.63
67912	Correction eyelid w/implant	Y	A2	$510.00	17.1243	$728.52	$564.63

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
67914	Repair eyelid defect	Y	A2	$510.00	17.1243	$728.52	$564.63
67915	Repair eyelid defect	Y	P3		4.2329	$180.08	$180.08
67916	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67917	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67921	Repair eyelid defect	Y	A2	$510.00	17.1243	$728.52	$564.63
67922	Repair eyelid defect	Y	P3		4.1685	$177.34	$177.34
67923	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67924	Repair eyelid defect	Y	A2	$630.00	17.1243	$728.52	$654.63
67930	Repair eyelid wound	Y	P3		4.1121	$174.94	$174.94
67935	Repair eyelid wound	Y	A2	$446.00	17.1243	$728.52	$516.63
67938	Remove eyelid foreign body	N	P2		1.1607	$49.38	$49.38
67950	Revision of eyelid	Y	A2	$446.00	17.1243	$728.52	$516.63
67961	Revision of eyelid	Y	A2	$510.00	17.1243	$728.52	$564.63
67966	Revision of eyelid	Y	A2	$510.00	17.1243	$728.52	$564.63
67971	Reconstruction of eyelid	Y	A2	$510.00	25.2550	$1,074.42	$651.11
67973	Reconstruction of eyelid	Y	A2	$510.00	25.2550	$1,074.42	$651.11
67974	Reconstruction of eyelid	Y	A2	$510.00	25.2550	$1,074.42	$651.11
67975	Reconstruction of eyelid	Y	A2	$510.00	17.1243	$728.52	$564.63
68020	Incise/drain eyelid lining	Y	P3		1.0864	$46.22	$46.22
68040	Treatment of eyelid lesions	N	P3		0.5392	$22.94	$22.94
68100	Biopsy of eyelid lining	Y	P3		2.2775	$96.89	$96.89
68110	Remove eyelid lining lesion	Y	P3		2.9131	$123.93	$123.93
68115	Remove eyelid lining lesion	Y	A2	$446.00	17.1243	$728.52	$516.63
68130	Remove eyelid lining lesion	Y	A2	$446.00	15.2259	$647.76	$496.44
68135	Remove eyelid lining lesion	Y	P3		1.3922	$59.23	$59.23
68200	Treat eyelid by injection	N	P3		0.4024	$17.12	$17.12
68320	Revise/graft eyelid lining	Y	A2	$630.00	17.1243	$728.52	$654.63
68325	Revise/graft eyelid lining	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68326	Revise/graft eyelid lining	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68328	Revise/graft eyelid lining	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68330	Revise eyelid lining	Y	A2	$630.00	22.9970	$978.36	$717.09
68335	Revise/graft eyelid lining	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68340	Separate eyelid adhesions	Y	A2	$630.00	17.1243	$728.52	$654.63
68360	Revise eyelid lining	Y	A2	$446.00	22.9970	$978.36	$579.09
68362	Revise eyelid lining	Y	A2	$446.00	22.9970	$978.36	$579.09
68371	Harvest eye tissue, alograft	Y	A2	$446.00	15.2259	$647.76	$496.44
68400	Incise/drain tear gland	Y	P2		2.8954	$123.18	$123.18
68420	Incise/drain tear sac	Y	P3		4.3777	$186.24	$186.24
68440	Incise tear duct opening	Y	P3		1.3520	$57.52	$57.52
68500	Removal of tear gland	Y	A2	$510.00	25.2550	$1,074.42	$651.11
68505	Partial removal, tear gland	Y	A2	$510.00	25.2550	$1,074.42	$651.11
68510	Biopsy of tear gland	Y	A2	$333.00	17.1243	$728.52	$431.88
68520	Removal of tear sac	Y	A2	$510.00	25.2550	$1,074.42	$651.11
68525	Biopsy of tear sac	Y	A2	$333.00	17.1243	$728.52	$431.88
68530	Clearance of tear duct	Y	P3		5.5929	$237.94	$237.94
68540	Remove tear gland lesion	Y	A2	$510.00	25.2550	$1,074.42	$651.11
68550	Remove tear gland lesion	Y	A2	$510.00	25.2550	$1,074.42	$651.11
68700	Repair tear ducts	Y	A2	$446.00	25.2550	$1,074.42	$603.11
68705	Revise tear duct opening	Y	P2		2.8954	$123.18	$123.18
68720	Create tear sac drain	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68745	Create tear duct drain	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68750	Create tear duct drain	Y	A2	$630.00	25.2550	$1,074.42	$741.11
68760	Close tear duct opening	N	P2		2.1451	$91.26	$91.26
68761	Close tear duct opening	N	P3		1.6658	$70.87	$70.87
68770	Close tear system fistula	Y	A2	$630.00	17.1243	$728.52	$654.63
68801	Dilate tear duct opening	N	P2		1.1607	$49.38	$49.38
68810	Probe nasolacrimal duct	N	A2	$131.86	2.1451	$91.26	$121.71
68811	Probe nasolacrimal duct	Y	A2	$446.00	17.1243	$728.52	$516.63
68815	Probe nasolacrimal duct	Y	A2	$446.00	17.1243	$728.52	$516.63
68840	Explore/irrigate tear ducts	N	P2		1.1607	$49.38	$49.38
68850	Injection for tear sac x-ray		N1				
69000	Drain external ear lesion	Y	P2		1.4392	$61.23	$61.23
69005	Drain external ear lesion	Y	P3		2.2934	$97.57	$97.57

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
69020	Drain outer ear canal lesion	Y	P2		1.4392	$61.23	$61.23
69100	Biopsy of external ear	Y	P3		1.4404	$61.28	$61.28
69105	Biopsy of external ear canal	Y	P3		1.9474	$82.85	$82.85
69110	Remove external ear, partial	Y	A2	$333.00	15.1024	$642.50	$410.38
69120	Removal of external ear	Y	A2	$446.00	23.3299	$992.52	$582.63
69140	Remove ear canal lesion(s)	Y	A2	$446.00	23.3299	$992.52	$582.63
69145	Remove ear canal lesion(s)	Y	A2	$446.00	15.1024	$642.50	$495.13
69150	Extensive ear canal surgery	Y	A2	$464.15	7.5511	$321.25	$428.43
69200	Clear outer ear canal	N	P2		0.6102	$25.96	$25.96
69205	Clear outer ear canal	Y	A2	$333.00	20.0656	$853.65	$463.16
69210	Remove impacted ear wax	N	P3		0.4748	$20.20	$20.20
69220	Clean out mastoid cavity	Y	P2		0.8432	$35.87	$35.87
69222	Clean out mastoid cavity	Y	P3		3.0339	$129.07	$129.07
69300	Revise external ear	Y	A2	$510.00	23.3299	$992.52	$630.63
69310	Rebuild outer ear canal	Y	A2	$510.00	38.1991	$1,625.10	$788.78
69320	Rebuild outer ear canal	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69400	Inflate middle ear canal	Y	P3		1.9152	$81.48	$81.48
69401	Inflate middle ear canal	Y	P3		1.0944	$46.56	$46.56
69405	Catheterize middle ear canal	Y	P3		2.7842	$118.45	$118.45
69420	Incision of eardrum	Y	P2		2.4520	$104.32	$104.32
69421	Incision of eardrum	Y	A2	$510.00	16.4266	$698.84	$557.21
69424	Remove ventilating tube	Y	P3		1.7542	$74.63	$74.63
69433	Create eardrum opening	Y	P3		2.4787	$105.45	$105.45
69436	Create eardrum opening	Y	A2	$510.00	16.4266	$698.84	$557.21
69440	Exploration of middle ear	Y	A2	$510.00	23.3299	$992.52	$630.63
69450	Eardrum revision	Y	A2	$333.00	38.1991	$1,625.10	$656.03
69501	Mastoidectomy	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69502	Mastoidectomy	Y	A2	$995.00	23.3299	$992.52	$994.38
69505	Remove mastoid structures	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69511	Extensive mastoid surgery	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69530	Extensive mastoid surgery	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69540	Remove ear lesion	Y	P3		2.9615	$125.99	$125.99
69550	Remove ear lesion	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69552	Remove ear lesion	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69601	Mastoid surgery revision	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69602	Mastoid surgery revision	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69603	Mastoid surgery revision	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69604	Mastoid surgery revision	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69605	Mastoid surgery revision	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69610	Repair of eardrum	Y	P3		4.0477	$172.20	$172.20
69620	Repair of eardrum	Y	A2	$446.00	23.3299	$992.52	$582.63
69631	Repair eardrum structures	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69632	Rebuild eardrum structures	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69633	Rebuild eardrum structures	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69635	Repair eardrum structures	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69636	Rebuild eardrum structures	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69637	Rebuild eardrum structures	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69641	Revise middle ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69642	Revise middle ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69643	Revise middle ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69644	Revise middle ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69645	Revise middle ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69646	Revise middle ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69650	Release middle ear bone	Y	A2	$995.00	23.3299	$992.52	$994.38
69660	Revise middle ear bone	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69661	Revise middle ear bone	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69662	Revise middle ear bone	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69666	Repair middle ear structures	Y	A2	$630.00	38.1991	$1,625.10	$878.78
69667	Repair middle ear structures	Y	A2	$630.00	38.1991	$1,625.10	$878.78
69670	Remove mastoid air cells	Y	A2	$510.00	38.1991	$1,625.10	$788.78
69676	Remove middle ear nerve	Y	A2	$510.00	38.1991	$1,625.10	$788.78
69700	Close mastoid fistula	Y	A2	$510.00	38.1991	$1,625.10	$788.78
69711	Remove/repair hearing aid	Y	A2	$333.00	38.1991	$1,625.10	$656.03

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

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

ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

HCPCS code	Short descriptor	Subject to multiple procedure discounting	Payment indicator	CY 2007 ASC payment rate	Estimated fully implemented payment weight	Estimated CY 2008 fully implemented payment	Estimated CY 2008 first transition year payment
69714	Implant temple bone w/stimul	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
69715	Temple bne implnt w/stimulat	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
69717	Temple bone implant revision	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
69718	Revise temple bone implant	Y	A2	$1,339.00	38.1991	$1,625.10	$1,410.53
69720	Release facial nerve	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69740	Repair facial nerve	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69745	Repair facial nerve	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69801	Incise inner ear	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69802	Incise inner ear	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69805	Explore inner ear	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69806	Explore inner ear	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69820	Establish inner ear window	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69840	Revise inner ear window	Y	A2	$717.00	38.1991	$1,625.10	$944.03
69905	Remove inner ear	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69910	Remove inner ear & mastoid	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69915	Incise inner ear nerve	Y	A2	$995.00	38.1991	$1,625.10	$1,152.53
69930	Implant cochlear device	Y	H8	$995.00	587.7216	$25,003.44	$23,712.58
69990	Microsurgery add-on		N1				
C9716	Radiofrequency energy to anu	Y	G2		29.6189	$1,260.08	$1,260.08
C9724	EPS gast cardia plic	Y	G2		25.7552	$1,095.70	$1,095.70
C9725	Place endorectal app	N	G2		8.9477	$380.66	$380.66
C9726	Rxt breast appl place/remov	N	G2		10.5746	$449.88	$449.88
C9727	Insert palate implants	N	G2		13.8283	$588.30	$588.30
G0104	CA screen;flexi sigmoidscope	N	P3		1.9152	$81.48	$81.48
G0105	Colorectal scrn; hi risk ind	Y	A2	$446.00	7.8492	$333.93	$417.98
G0121	Colon ca scrn not hi rsk ind	Y	A2	$446.00	7.8492	$333.93	$417.98
G0127	Trim nail(s)	Y	P3		0.2494	$10.61	$10.61
G0186	Dstry eye lesn,fdr vssl tech	Y	R2		3.9333	$167.33	$167.33
G0247	Routine footcare pt w lops	Y	P3		0.4828	$20.54	$20.54
G0259	Inject for sacroiliac joint		N1				
G0260	Inj for sacroiliac jt anesth	Y	A2	$333.00	5.7253	$243.57	$310.64
G0268	Removal of impacted wax md	N	P3		0.4990	$21.23	$21.23
G0269	Occlusive device in vein art		N1				
G0289	Arthro, loose body + chondro		N1				
G0297	Insert single chamber/cd	Y	J8		440.1206	$18,724.05	$18,724.05
G0298	Insert dual chamber/cd	Y	J8		440.1206	$18,724.05	$18,724.05
G0299	Inser/repos single icd+leads	Y	J8		546.9370	$23,268.34	$23,268.34
G0300	Insert reposit lead dual+gen	Y	J8		546.9370	$23,268.34	$23,268.34
G0364	Bone marrow aspirate & biopsy	Y	P3		0.1208	$5.14	$5.14
G0392	AV fistula or graft arterial	Y	A2	$1,339.00	42.9360	$1,826.63	$1,460.91
G0393	AV fistula or graft venous	Y	A2	$1,339.00	42.9360	$1,826.63	$1,460.91

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

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
0028T	Dexa body composition study	N1		
0042T	Ct perfusion w/contrast, cbf	N1		
0054T	Bone surgery using computer	Z2	4.9138	$209.05
0055T	Bone surgery using computer	Z2	4.9138	$209.05
0056T	Bone surgery using computer	Z2	4.9138	$209.05
0067T	Ct colonography;dx	Z2	4.8405	$205.93
0071T	U/s leiomyomata ablate <200	Z2	28.5095	$1,212.88
0072T	U/s leiomyomata ablate >200	Z2	42.9896	$1,828.91
0073T	Delivery, comp imrt	Z2	5.4731	$232.84
0126T	Chd risk imt study	N1		
0144T	CT heart wo dye; qual calc	Z2	4.1265	$175.55
0145T	CT heart w/wo dye funct	Z2	4.9832	$212.00
0146T	CCTA w/wo dye	Z2	4.9832	$212.00
0147T	CCTA w/wo, quan calcium	Z2	4.9832	$212.00
0148T	CCTA w/wo, strxr	Z2	6.5012	$276.58
0149T	CCTA w/wo, strxr quan calc	Z2	6.5012	$276.58
0150T	CCTA w/wo, disease strxr	Z2	4.1265	$175.55
0151T	CT heart funct add-on	Z2	1.5379	$65.43
0159T	Cad breast mri	N1		
0174T	Cad cxr with interp	N1		
0175T	Cad cxr remote	N1		
70010	Contrast x-ray of brain	Z2	2.5544	$108.67
70015	Contrast x-ray of brain	Z3	1.4806	$62.99
70030	X-ray eye for foreign body	Z3	0.3782	$16.09
70100	X-ray exam of jaw	Z3	0.4346	$18.49
70110	X-ray exam of jaw	Z3	0.5230	$22.25
70120	X-ray exam of mastoids	Z3	0.4990	$21.23
70130	X-ray exam of mastoids	Z2	0.7093	$30.18
70134	X-ray exam of middle ear	Z3	0.6036	$25.68
70140	X-ray exam of facial bones	Z3	0.4346	$18.49
70150	X-ray exam of facial bones	Z3	0.6116	$26.02
70160	X-ray exam of nasal bones	Z3	0.4506	$19.17
70170	X-ray exam of tear duct	Z2	2.9586	$125.87
70190	X-ray exam of eye sockets	Z3	0.4990	$21.23
70200	X-ray exam of eye sockets	Z3	0.6116	$26.02
70210	X-ray exam of sinuses	Z3	0.4506	$19.17
70220	X-ray exam of sinuses	Z3	0.5632	$23.96
70240	X-ray exam, pituitary saddle	Z3	0.3862	$16.43
70250	X-ray exam of skull	Z3	0.4908	$20.88
70260	X-ray exam of skull	Z3	0.6518	$27.73
70300	X-ray exam of teeth	Z3	0.1932	$8.22
70310	X-ray exam of teeth	Z3	0.4828	$20.54
70320	Full mouth x-ray of teeth	Z2	0.6550	$27.87
70328	X-ray exam of jaw joint	Z3	0.4104	$17.46
70330	X-ray exam of jaw joints	Z3	0.6920	$29.44
70332	X-ray exam of jaw joint	Z3	1.3520	$57.52
70336	Magnetic image, jaw joint	Z2	4.5523	$193.67
70350	X-ray head for orthodontia	Z3	0.2576	$10.96
70355	Panoramic x-ray of jaws	Z3	0.3218	$13.69
70360	X-ray exam of neck	Z3	0.3622	$15.41
70370	Throat x-ray & fluoroscopy	Z3	1.1346	$48.27
70371	Speech evaluation, complex	Z2	1.2908	$54.91
70373	Contrast x-ray of larynx	Z3	1.3036	$55.46
70380	X-ray exam of salivary gland	Z3	0.5714	$24.31
70390	X-ray exam of salivary duct	Z3	1.5612	$66.42
70450	Ct head/brain w/o dye	Z2	3.0908	$131.49
70460	Ct head/brain w/dye	Z2	4.0825	$173.68
70470	Ct head/brain w/o & w/dye	Z2	4.8405	$205.93
70480	Ct orbit/ear/fossa w/o dye	Z2	3.0908	$131.49
70481	Ct orbit/ear/fossa w/dye	Z2	4.0825	$173.68
70482	Ct orbit/ear/fossa w/o & w/dye	Z2	4.8405	$205.93
70486	Ct maxillofacial w/o dye	Z2	3.0908	$131.49
70487	Ct maxillofacial w/dye	Z2	4.0825	$173.68
70488	Ct maxillofacial w/o & w/dye	Z2	4.8405	$205.93

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
70490	Ct soft tissue neck w/o dye	Z2	3.0908	$131.49
70491	Ct soft tissue neck w/dye	Z2	4.0825	$173.68
70492	Ct sft tsue nck w/o & w/dye	Z2	4.8405	$205.93
70496	Ct angiography, head	Z2	4.8552	$206.55
70498	Ct angiography, neck	Z2	4.8552	$206.55
70540	Mri orbit/face/neck w/o dye	Z2	5.6745	$241.41
70542	Mri orbit/face/neck w/dye	Z2	6.1231	$260.50
70543	Mri orbt/fac/nck w/o & w/dye	Z2	8.1155	$345.26
70544	Mr angiography head w/o dye	Z2	5.6745	$241.41
70545	Mr angiography head w/dye	Z2	6.1231	$260.50
70546	Mr angiograph head w/o & w/dye	Z2	8.1155	$345.26
70547	Mr angiography neck w/o dye	Z2	5.6745	$241.41
70548	Mr angiography neck w/dye	Z2	6.1231	$260.50
70549	Mr angiograph neck w/o & w/dye	Z2	8.1155	$345.26
70551	Mri brain w/o dye	Z2	5.6745	$241.41
70552	Mri brain w/dye	Z2	6.1231	$260.50
70553	Mri brain w/o & w/dye	Z2	8.1155	$345.26
70554	Fmri brain by tech	Z2	5.6745	$241.41
70555	Fmri brain by phys/psych	Z2	5.6745	$241.41
70557	Mri brain w/o dye	Z2	5.6745	$241.41
70558	Mri brain w/dye	Z2	6.1231	$260.50
70559	Mri brain w/o & w/dye	Z2	8.1155	$345.26
71010	Chest x-ray	Z3	0.3300	$14.04
71015	Chest x-ray	Z3	0.4024	$17.12
71020	Chest x-ray	Z3	0.4426	$18.83
71021	Chest x-ray	Z3	0.5392	$22.94
71022	Chest x-ray	Z3	0.6036	$25.68
71023	Chest x-ray and fluoroscopy	Z3	0.8690	$36.97
71030	Chest x-ray	Z3	0.6276	$26.70
71034	Chest x-ray and fluoroscopy	Z2	1.2908	$54.91
71035	Chest x-ray	Z3	0.4828	$20.54
71040	Contrast x-ray of bronchi	Z3	1.3278	$56.49
71060	Contrast x-ray of bronchi	Z2	1.6956	$72.14
71090	X-ray & pacemaker insertion	Z2	1.2908	$54.91
71100	X-ray exam of ribs	Z3	0.4426	$18.83
71101	X-ray exam of ribs/chest	Z3	0.5230	$22.25
71110	X-ray exam of ribs	Z3	0.5794	$24.65
71111	X-ray exam of ribs/chest	Z3	0.7322	$31.15
71120	X-ray exam of breastbone	Z3	0.4748	$20.20
71130	X-ray exam of breastbone	Z3	0.5472	$23.28
71250	Ct thorax w/o dye	Z2	3.0908	$131.49
71260	Ct thorax w/dye	Z2	4.0825	$173.68
71270	Ct thorax w/o & w/dye	Z2	4.8405	$205.93
71275	Ct angiography, chest	Z2	4.8552	$206.55
71550	Mri chest w/o dye	Z2	5.6745	$241.41
71551	Mri chest w/dye	Z2	6.1231	$260.50
71552	Mri chest w/o & w/dye	Z2	8.1155	$345.26
72010	X-ray exam of spine	Z2	0.7093	$30.18
72020	X-ray exam of spine	Z3	0.3218	$13.69
72040	X-ray exam of neck spine	Z3	0.5150	$21.91
72050	X-ray exam of neck spine	Z3	0.7322	$31.15
72052	X-ray exam of neck spine	Z3	0.9416	$40.06
72069	X-ray exam of trunk spine	Z3	0.4586	$19.51
72070	X-ray exam of thoracic spine	Z3	0.4748	$20.20
72072	X-ray exam of thoracic spine	Z3	0.5552	$23.62
72074	X-ray exam of thoracic spine	Z3	0.7000	$29.78
72080	X-ray exam of trunk spine	Z3	0.5070	$21.57
72090	X-ray exam of trunk spine	Z3	0.6196	$26.36
72100	X-ray exam of lower spine	Z3	0.5552	$23.62
72110	X-ray exam of lower spine	Z3	0.7644	$32.52
72114	X-ray exam of lower spine	Z3	1.0380	$44.16
72120	X-ray exam of lower spine	Z3	0.7484	$31.84
72125	Ct neck spine w/o dye	Z2	3.0908	$131.49
72126	Ct neck spine w/dye	Z2	4.0825	$173.68

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
72127	Ct neck spine w/o & w/dye	Z2	4.8405	$205.93
72128	Ct chest spine w/o dye	Z2	3.0908	$131.49
72129	Ct chest spine w/dye	Z2	4.0825	$173.68
72130	Ct chest spine w/o & w/dye	Z2	4.8405	$205.93
72131	Ct lumbar spine w/o dye	Z2	3.0908	$131.49
72132	Ct lumbar spine w/dye	Z2	4.0825	$173.68
72133	Ct lumbar spine w/o & w/dye	Z2	4.8405	$205.93
72141	Mri neck spine w/o dye	Z2	5.6745	$241.41
72142	Mri neck spine w/dye	Z2	6.1231	$260.50
72146	Mri chest spine w/o dye	Z2	5.6745	$241.41
72147	Mri chest spine w/dye	Z2	6.1231	$260.50
72148	Mri lumbar spine w/o dye	Z2	5.6745	$241.41
72149	Mri lumbar spine w/dye	Z2	6.1231	$260.50
72156	Mri neck spine w/o & w/dye	Z2	8.1155	$345.26
72157	Mri chest spine w/o & w/dye	Z2	8.1155	$345.26
72158	Mri lumbar spine w/o & w/dye	Z2	8.1155	$345.26
72170	X-ray exam of pelvis	Z3	0.3782	$16.09
72190	X-ray exam of pelvis	Z3	0.5714	$24.31
72191	Ct angiograph pelv w/o & w/dye	Z2	4.8552	$206.55
72192	Ct pelvis w/o dye	Z2	3.0908	$131.49
72193	Ct pelvis w/dye	Z2	4.0825	$173.68
72194	Ct pelvis w/o & w/dye	Z2	4.8405	$205.93
72195	Mri pelvis w/o dye	Z2	5.6745	$241.41
72196	Mri pelvis w/dye	Z2	6.1231	$260.50
72197	Mri pelvis w/o & w/dye	Z2	8.1155	$345.26
72200	X-ray exam sacroiliac joints	Z3	0.4184	$17.80
72202	X-ray exam sacroiliac joints	Z3	0.5070	$21.57
72220	X-ray exam of tailbone	Z3	0.4264	$18.14
72240	Contrast x-ray of neck spine	Z2	2.5544	$108.67
72255	Contrast x-ray, thorax spine	Z3	2.5026	$106.47
72265	Contrast x-ray, lower spine	Z3	2.4867	$105.79
72270	Contrast x-ray, spine	Z2	2.5544	$108.67
72275	Epidurography	Z3	1.4404	$61.28
72285	X-ray c/t spine disk	Z3	3.8145	$162.28
72291	Perq vertebroplasty, fluor	Z2	2.5544	$108.67
72292	Perq vertebroplasty, ct	Z2	2.5544	$108.67
72295	X-ray of lower spine disk	Z3	3.6213	$154.06
73000	X-ray exam of collar bone	Z3	0.4024	$17.12
73010	X-ray exam of shoulder blade	Z3	0.4184	$17.80
73020	X-ray exam of shoulder	Z3	0.3460	$14.72
73030	X-ray exam of shoulder	Z3	0.4264	$18.14
73040	Contrast x-ray of shoulder	Z3	1.6256	$69.16
73050	X-ray exam of shoulders	Z3	0.5230	$22.25
73060	X-ray exam of humerus	Z3	0.4264	$18.14
73070	X-ray exam of elbow	Z3	0.4024	$17.12
73080	X-ray exam of elbow	Z3	0.4990	$21.23
73085	Contrast x-ray of elbow	Z3	1.4806	$62.99
73090	X-ray exam of forearm	Z3	0.4024	$17.12
73092	X-ray exam of arm, infant	Z3	0.4024	$17.12
73100	X-ray exam of wrist	Z3	0.4104	$17.46
73110	X-ray exam of wrist	Z3	0.4908	$20.88
73115	Contrast x-ray of wrist	Z3	1.4806	$62.99
73120	X-ray exam of hand	Z3	0.3944	$16.78
73130	X-ray exam of hand	Z3	0.4426	$18.83
73140	X-ray exam of finger(s)	Z3	0.4184	$17.80
73200	Ct upper extremity w/o dye	Z2	3.0908	$131.49
73201	Ct upper extremity w/dye	Z2	4.0825	$173.68
73202	Ct uppr extremity w/o & w/dye	Z2	4.8405	$205.93
73206	Ct angio upr extrm w/o & w/dye	Z2	4.8552	$206.55
73218	Mri upper extremity w/o dye	Z2	5.6745	$241.41
73219	Mri upper extremity w/dye	Z2	6.1231	$260.50
73220	Mri uppr extremity w/o & w/dye	Z2	8.1155	$345.26
73221	Mri joint upr extrem w/o dye	Z2	5.6745	$241.41
73222	Mri joint upr extrem w/dye	Z2	6.1231	$260.50

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
73223	Mri joint upr extr w/o & w/dye	Z2	8.1155	$345.26
73500	X-ray exam of hip	Z3	0.3540	$15.06
73510	X-ray exam of hip	Z3	0.5070	$21.57
73520	X-ray exam of hips	Z3	0.5392	$22.94
73525	Contrast x-ray of hip	Z3	1.4726	$62.65
73530	X-ray exam of hip	Z2	1.2224	$52.00
73540	X-ray exam of pelvis & hips	Z3	0.5150	$21.91
73542	X-ray exam, sacroiliac joint	Z3	1.2312	$52.38
73550	X-ray exam of thigh	Z3	0.4184	$17.80
73560	X-ray exam of knee, 1 or 2	Z3	0.4184	$17.80
73562	X-ray exam of knee, 3	Z3	0.4908	$20.88
73564	X-ray exam, knee, 4 or more	Z3	0.5552	$23.62
73565	X-ray exam of knees	Z3	0.4264	$18.14
73580	Contrast x-ray of knee joint	Z3	1.9152	$81.48
73590	X-ray exam of lower leg	Z3	0.3944	$16.78
73592	X-ray exam of leg, infant	Z3	0.4104	$17.46
73600	X-ray exam of ankle	Z3	0.3944	$16.78
73610	X-ray exam of ankle	Z3	0.4506	$19.17
73615	Contrast x-ray of ankle	Z3	1.5128	$64.36
73620	X-ray exam of foot	Z3	0.3944	$16.78
73630	X-ray exam of foot	Z3	0.4426	$18.83
73650	X-ray exam of heel	Z3	0.3862	$16.43
73660	X-ray exam of toe(s)	Z3	0.4024	$17.12
73700	Ct lower extremity w/o dye	Z2	3.0908	$131.49
73701	Ct lower extremity w/dye	Z2	4.0825	$173.68
73702	Ct lwr extremity w/o & w/dye	Z2	4.8405	$205.93
73706	Ct angio lwr extr w/o & w/dye	Z2	4.8552	$206.55
73718	Mri lower extremity w/o dye	Z2	5.6745	$241.41
73719	Mri lower extremity w/dye	Z2	6.1231	$260.50
73720	Mri lwr extremity w/o & w/dye	Z2	8.1155	$345.26
73721	Mri jnt of lwr extre w/o dye	Z2	5.6745	$241.41
73722	Mri joint of lwr extr w/dye	Z2	6.1231	$260.50
73723	Mri joint lwr extr w/o & w/dye	Z2	8.1155	$345.26
74000	X-ray exam of abdomen	Z3	0.3622	$15.41
74010	X-ray exam of abdomen	Z3	0.5070	$21.57
74020	X-ray exam of abdomen	Z3	0.5150	$21.91
74022	X-ray exam series, abdomen	Z3	0.6196	$26.36
74150	Ct abdomen w/o dye	Z2	3.0908	$131.49
74160	Ct abdomen w/dye	Z2	4.0825	$173.68
74170	Ct abdomen w/o & w/dye	Z2	4.8405	$205.93
74175	Ct angio abdom w/o & w/dye	Z2	4.8552	$206.55
74181	Mri abdomen w/o dye	Z2	5.6745	$241.41
74182	Mri abdomen w/dye	Z2	6.1231	$260.50
74183	Mri abdomen w/o & w/dye	Z2	8.1155	$345.26
74190	X-ray exam of peritoneum	Z2	2.9586	$125.87
74210	Contrst x-ray exam of throat	Z3	1.1024	$46.90
74220	Contrast x-ray, esophagus	Z3	1.1830	$50.33
74230	Cine/vid x-ray, throat/esoph	Z3	1.1990	$51.01
74235	Remove esophagus obstruction	Z2	1.0974	$46.69
74240	X-ray exam, upper gi tract	Z3	1.3680	$58.20
74241	X-ray exam, upper gi tract	Z2	1.4294	$60.81
74245	X-ray exam, upper gi tract	Z2	2.2176	$94.34
74246	Contrst x-ray uppr gi tract	Z2	1.4294	$60.81
74247	Contrst x-ray uppr gi tract	Z2	1.4294	$60.81
74249	Contrst x-ray uppr gi tract	Z2	2.2176	$94.34
74250	X-ray exam of small bowel	Z3	1.4082	$59.91
74251	X-ray exam of small bowel	Z2	2.2176	$94.34
74260	X-ray exam of small bowel	Z2	1.4294	$60.81
74270	Contrast x-ray exam of colon	Z2	1.4294	$60.81
74280	Contrast x-ray exam of colon	Z2	2.2176	$94.34
74283	Contrast x-ray exam of colon	Z2	1.4294	$60.81
74290	Contrast x-ray, gallbladder	Z3	0.8450	$35.95
74291	Contrast x-rays, gallbladder	Z3	0.7726	$32.87
74300	X-ray bile ducts/pancreas	Z2	1.6956	$72.14

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
74301	X-rays at surgery add-on	Z2	1.6956	$72.14
74305	X-ray bile ducts/pancreas	Z2	1.6956	$72.14
74320	Contrast x-ray of bile ducts	Z3	2.0039	$85.25
74327	X-ray bile stone removal	Z3	1.7462	$74.29
74328	X-ray bile duct endoscopy	N1		
74329	X-ray for pancreas endoscopy	N1		
74330	X-ray bile/panc endoscopy	N1		
74340	X-ray guide for GI tube	Z2	1.2908	$54.91
74350	X-ray guide, stomach tube	Z2	1.6956	$72.14
74355	X-ray guide, intestinal tube	Z2	1.6956	$ 72.14
74360	X-ray guide, GI dilation	Z2	1.0974	$46.69
74363	X-ray, bile duct dilation	Z2	3.6392	$154.82
74400	Contrst x-ray, urinary tract	Z3	1.6094	$68.47
74410	Contrst x-ray, urinary tract	Z3	1.7625	$74.98
74415	Contrst x-ray, urinary tract	Z3	2.0440	$86.96
74420	Contrst x-ray, urinary tract	Z2	2.4159	$102.78
74425	Contrst x-ray, urinary tract	Z2	2.4159	$102.78
74430	Contrast x-ray, bladder	Z3	1.1346	$48.27
74440	X-ray, male genital tract	Z3	1.2634	$53.75
74445	X-ray exam of penis	Z2	2.4159	$102.78
74450	X-ray, urethra/bladder	Z2	2.4159	$102.78
74455	X-ray, urethra/bladder	Z3	1.4324	$60.94
74470	X-ray exam of kidney lesion	Z2	1.6956	$72.14
74475	X-ray control, cath insert	Z3	2.3738	$100.99
74480	X-ray control, cath insert	Z3	2.3738	$100.99
74485	X-ray guide, GU dilation	Z3	2.0683	$87.99
74710	X-ray measurement of pelvis	Z3	0.6276	$26.70
74740	X-ray, female genital tract	Z3	1.1508	$48.96
74742	X-ray, fallopian tube	Z2	2.9586	$125.87
74775	X-ray exam of perineum	Z2	2.4159	$102.78
75552	Heart mri for morph w/o dye	Z2	5.6745	$241.41
75553	Heart mri for morph w/dye	Z2	6.1231	$260.50
75554	Cardiac MRI/function	Z2	5.6745	$241.41
75555	Cardiac MRI/limited study	Z2	5.6745	$241.41
75600	Contrast x-ray exam of aorta	Z3	7.5404	$320.79
75605	Contrast x-ray exam of aorta	Z3	6.2929	$267.72
75625	Contrast x-ray exam of aorta	Z3	6.2125	$264.30
75630	X-ray aorta, leg arteries	Z3	6.4941	$276.28
75635	Ct angio abdominal arteries	Z2	4.8552	$206.55
75650	Artery x-rays, head & neck	Z3	6.2125	$264.30
75658	Artery x-rays, arm	Z3	6.3815	$271.49
75660	Artery x-rays, head & neck	Z2	6.2463	$265.74
75662	Artery x-rays, head & neck	Z3	6.7840	$288.61
75665	Artery x-rays, head & neck	Z3	6.4699	$275.25
75671	Artery x-rays, head & neck	Z3	6.7920	$288.95
75676	Artery x-rays, neck	Z3	6.3815	$271.49
75680	Artery x-rays, neck	Z3	6.5987	$280.73
75685	Artery x-rays, spine	Z3	6.3736	$271.15
75705	Artery x-rays, spine	Z2	6.2463	$265.74
75710	Artery x-rays, arm/leg	Z3	6.4619	$274.91
75716	Artery x-rays, arms/legs	Z3	6.7920	$288.95
75722	Artery x-rays, kidney	Z3	6.4055	$272.51
75724	Artery x-rays, kidneys	Z3	6.8242	$290.32
75726	Artery x-rays, abdomen	Z3	6.3413	$269.78
75731	Artery x-rays, adrenal gland	Z3	6.4055	$272.51
75733	Artery x-rays, adrenals	Z2	6.2463	$265.74
75736	Artery x-rays, pelvis	Z3	6.3975	$272.17
75741	Artery x-rays, lung	Z3	6.0999	$259.51
75743	Artery x-rays, lungs	Z3	6.1963	$263.61
75746	Artery x-rays, lung	Z3	6.2607	$266.35
75756	Artery x-rays, chest	Z3	6.5828	$280.05
75774	Artery x-ray, each vessel	Z3	6.0033	$255.40
75790	Visualize A-V shunt	Z3	1.5210	$64.71
75801	Lymph vessel x-ray, arm/leg	Z2	2.9586	$125.87

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
75803	Lymph vessel x-ray, arms/legs	Z2	2.9586	$125.87
75805	Lymph vessel x-ray, trunk	Z2	2.9586	$125.87
75807	Lymph vessel x-ray, trunk	Z2	2.9586	$125.87
75809	Nonvascular shunt, x-ray	Z3	1.0864	$46.22
75810	Vein x-ray, spleen/liver	Z2	9.5061	$404.42
75820	Vein x-ray, arm/leg	Z3	1.4484	$61.62
75822	Vein x-ray, arms/legs	Z3	1.6738	$71.21
75825	Vein x-ray, trunk	Z3	6.0515	$257.45
75827	Vein x-ray, chest	Z3	6.0677	$258.14
75831	Vein x-ray, kidney	Z3	6.0999	$259.51
75833	Vein x-ray, kidneys	Z3	6.3009	$268.06
75840	Vein x-ray, adrenal gland	Z3	6.1723	$262.59
75842	Vein x-ray, adrenal glands	Z3	6.2769	$267.04
75860	Vein x-ray, neck	Z3	6.2285	$264.98
75870	Vein x-ray, skull	Z3	6.1641	$262.24
75872	Vein x-ray, skull	Z3	6.4459	$274.23
75880	Vein x-ray, eye socket	Z3	1.4484	$61.62
75885	Vein x-ray, liver	Z3	6.0837	$258.82
75887	Vein x-ray, liver	Z3	6.1561	$261.90
75889	Vein x-ray, liver	Z3	6.0837	$258.82
75891	Vein x-ray, liver	Z3	6.0837	$258.82
75893	Venous sampling by catheter	N1	.....	.....
75894	X-rays, transcath therapy	Z2	8.3906	$356.96
75896	X-rays, transcath therapy	Z2	8.3906	$356.96
75898	Follow-up angiography	Z2	1.6956	$72.14
75901	Remove cva device obstruct	Z2	1.6956	$72.14
75902	Remove cva lumen obstruct	Z3	1.1024	$46.90
75940	X-ray placement, vein filter	Z2	8.3906	$356.96
75945	Intravascular us	Z2	2.4606	$104.68
75946	Intravascular us add-on	Z2	1.5607	$66.40
75960	Transcath iv stent rs&i	Z2	6.2463	$265.74
75961	Retrieval, broken catheter	Z3	5.4399	$231.43
75962	Repair arterial blockage	Z2	6.2463	$265.74
75964	Repair artery blockage, each	Z3	4.2571	$181.11
75966	Repair arterial blockage	Z2	6.2463	$265.74
75968	Repair artery blockage, each	Z3	4.2731	$181.79
75970	Vascular biopsy	Z2	6.2463	$265.74
75978	Repair venous blockage	Z2	6.2463	$265.74
75980	Contrast xray exam bile duct	Z2	3.6392	$154.82
75982	Contrast xray exam bile duct	Z2	3.6392	$154.82
75984	Xray control catheter change	Z3	1.5692	$66.76
75989	Abscess drainage under x-ray	N1	.....	.....
75992	Atherectomy, x-ray exam	Z2	6.2463	$265.74
75993	Atherectomy, x-ray exam	Z2	6.2463	$265.74
75994	Atherectomy, x-ray exam	Z2	6.2463	$265.74
75995	Atherectomy, x-ray exam	Z2	6.2463	$265.74
75996	Atherectomy, x-ray exam	Z2	6.2463	$265.74
76000	Fluoroscope examination	Z2	1.2908	$54.91
76001	Fluoroscope exam, extensive	N1	.....	.....
76010	X-ray, nose to rectum	Z3	0.3944	$16.78
76080	X-ray exam of fistula	Z3	0.7644	$32.52
76098	X-ray exam, breast specimen	Z3	0.2736	$11.64
76100	X-ray exam of body section	Z2	1.2224	$52.00
76101	Complex body section x-ray	Z2	1.6956	$72.14
76102	Complex body section x-rays	Z2	2.9586	$125.87
76120	Cine/video x-rays	Z3	1.1024	$46.90
76125	Cine/video x-rays add-on	Z2	0.7093	$30.18
76150	X-ray exam, dry process	Z3	0.4346	$18.49
76350	Special x-ray contrast study	N1	.....	.....
76376	3d render w/o postprocess	Z2	0.6102	$25.96
76377	3d rendering w/postprocess	Z2	1.5379	$65.43
76380	CAT scan follow-up study	Z2	1.5379	$65.43
76496	Fluoroscopic procedure	Z2	1.2908	$54.91
76497	Ct procedure	Z2	1.5379	$65.43

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
76498	Mri procedure	Z2	4.5523	$193.67
76499	Radiographic procedure	Z2	0.7093	$30.18
76506	Echo exam of head	Z2	0.9923	$42.22
76510	Ophth us, b & quant a	Z2	1.5607	$66.40
76511	Ophth us, quant a only	Z3	1.2312	$52.38
76512	Ophth us, b w/non-quant a	Z3	1.0702	$45.53
76513	Echo exam of eye, water bath	Z3	1.1426	$48.61
76514	Echo exam of eye, thickness	Z3	0.0644	$2.74
76516	Echo exam of eye	Z3	0.8852	$37.66
76519	Echo exam of eye	Z3	0.9736	$41.42
76529	Echo exam of eye	Z3	0.8450	$35.95
76536	Us exam of head and neck	Z3	1.5290	$65.05
76604	Us exam, chest	Z2	0.9923	$42.22
76645	Us exam, breast(s)	Z2	0.9923	$42.22
76700	Us exam, abdom, complete	Z2	1.5607	$66.40
76705	Echo exam of abdomen	Z3	1.3922	$59.23
76770	Us exam abdo back wall, comp	Z2	1.5607	$66.40
76775	Us exam abdo back wall, lim	Z3	1.4002	$59.57
76776	Us exam k transpl w/doppler	Z2	1.5607	$66.40
76800	Us exam, spinal canal	Z3	1.3680	$58.20
76801	Ob us < 14 wks, single fetus	Z2	1.5607	$66.40
76802	Ob us < 14 wks, add'l fetus	Z3	0.7000	$29.78
76805	Ob us >/= 14 wks, sngl fetus	Z2	1.5607	$66.40
76810	Ob us >/= 14 wks, addl fetus	Z3	0.9576	$40.74
76811	Ob us, detailed, sngl fetus	Z3	2.4060	$102.36
76812	Ob us, detailed, addl fetus	Z2	0.9923	$42.22
76813	Ob us nuchal meas, 1 gest	Z3	1.3922	$59.23
76814	Ob us nuchal meas, add-on	Z3	0.6760	$28.76
76815	Ob us, limited, fetus(s)	Z2	0.9923	$42.22
76816	Ob us, follow-up, per fetus	Z2	0.9923	$42.22
76817	Transvaginal us, obstetric	Z2	0.9923	$42.22
76818	Fetal biophys profile w/nst	Z3	1.3922	$59.23
76819	Fetal biophys profil w/o nst	Z3	1.1990	$51.01
76820	Umbilical artery echo	Z3	0.8128	$34.58
76821	Middle cerebral artery echo	Z3	1.3036	$55.46
76825	Echo exam of fetal heart	Z2	1.5973	$67.95
76826	Echo exam of fetal heart	Z3	1.2794	$54.43
76827	Echo exam of fetal heart	Z3	1.0462	$44.51
76828	Echo exam of fetal heart	Z3	0.6358	$27.05
76830	Transvaginal us, non-ob	Z2	1.5607	$66.40
76831	Echo exam, uterus	Z3	1.6094	$68.47
76856	Us exam, pelvic, complete	Z2	1.5607	$66.40
76857	Us exam, pelvic, limited	Z2	0.9923	$42.22
76870	Us exam, scrotum	Z2	1.5607	$66.40
76872	Us, transrectal	Z2	1.5607	$66.40
76873	Echograp trans r, pros study	Z2	1.5607	$66.40
76880	Us exam, extremity	Z2	1.5607	$66.40
76885	Us exam infant hips, dynamic	Z2	0.9923	$42.22
76886	Us exam infant hips, static	Z2	0.9923	$42.22
76930	Echo guide, cardiocentesis	Z2	1.1882	$50.55
76932	Echo guide for heart biopsy	Z2	2.1012	$89.39
76936	Echo guide for artery repair	Z2	2.1012	$89.39
76937	Us guide, vascular access	N1	.....	.....
76940	Us guide, tissue ablation	Z2	1.1882	$50.55
76941	Echo guide for transfusion	Z2	1.1882	$50.55
76942	Echo guide for biopsy	Z2	1.1882	$50.55
76945	Echo guide, villus sampling	Z2	1.1882	$50.55
76946	Echo guide for amniocentesis	Z3	0.7404	$31.50
76948	Echo guide, ova aspiration	Z3	0.7404	$31.50
76950	Echo guidance radiotherapy	Z3	0.9416	$40.06
76965	Echo guidance radiotherapy	Z2	2.1012	$89.39
76970	Ultrasound exam follow-up	Z2	0.9923	$42.22
76975	GI endoscopic ultrasound	Z2	1.5607	$66.40
76977	Us bone density measure	Z3	0.3702	$15.75

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
76998	Us guide, intraop	Z2	1.5607	$66.40
76999	Echo examination procedure	Z2	0.9923	$42.22
77001	Fluoroguide for vein device	N1		
77002	Needle localization by xray	N1		
77003	Fluoroguide for spine inject	N1		
77011	Ct scan for localization	Z2	4.0825	$173.68
77012	Ct scan for needle biopsy	Z3	4.0559	$172.55
77013	Ct guide for tissue ablation	Z2	4.8405	$205.93
77014	Ct scan for therapy guide	Z2	1.5379	$65.43
77021	Mr guidance for needle place	Z2	4.5523	$193.67
77022	Mri for tissue ablation	Z2	4.5523	$193.67
77031	Stereotact guide for brst bx	Z2	2.9586	$125.87
77032	Guidance for needle, breast	Z3	0.6840	$29.10
77053	X-ray of mammary duct	Z3	1.2554	$53.41
77054	X-ray of mammary ducts	Z2	1.6956	$72.14
77071	X-ray stress view	Z3	0.3782	$16.09
77072	X-rays for bone age	Z3	0.2736	$11.64
77073	X-rays, bone length studies	Z3	0.5312	$22.60
77074	X-rays, bone survey, limited	Z3	0.8852	$37.66
77075	X-rays, bone survey complete	Z2	1.2224	$52.00
77076	X-rays, bone survey, infant	Z2	0.7093	$30.18
77077	Joint survey, single view	Z3	0.6598	$28.07
77078	Ct bone density, axial	Z2	1.1755	$50.01
77079	Ct bone density, peripheral	Z3	1.4566	$61.97
77080	Dxa bone density, axial	Z2	1.1755	$50.01
77081	Dxa bone density/peripheral	Z2	0.5497	$23.39
77082	Dxa bone density, vert fx	Z3	0.4426	$18.83
77083	Radiographic absorptiometry	Z3	0.4264	$18.14
77084	Magnetic image, bone marrow	Z2	4.5523	$193.67
77280	Sbrt management	Z2	1.5735	$66.94
77285	Set radiation therapy field	Z2	3.9723	$168.99
77290	Set radiation therapy field	Z2	3.9723	$168.99
77295	Set radiation therapy field	Z3	13.6401	$580.29
77299	Radiation therapy planning	Z2	1.5735	$66.94
77300	Radiation therapy dose plan	Z3	0.9334	$39.71
77301	Radiotherapy dose plan, imrt	Z2	13.8081	$587.44
77305	Teletx isodose plan simple	Z3	1.0140	$43.14
77310	Teletx isodose plan intermed	Z3	1.3036	$55.46
77315	Teletx isodose plan complex	Z3	1.7060	$72.58
77321	Special teletx port plan	Z3	2.1085	$89.70
77326	Brachytx isodose calc simp	Z2	1.5735	$66.94
77327	Brachytx isodose calc interm	Z3	2.8649	$121.88
77328	Brachytx isodose plan compl	Z3	3.8305	$162.96
77331	Special radiation dosimetry	Z3	0.4104	$17.46
77332	Radiation treatment aid(s)	Z3	1.0944	$46.56
77333	Radiation treatment aid(s)	Z3	0.8610	$36.63
77334	Radiation treatment aid(s)	Z3	2.2453	$95.52
77336	Radiation physics consult	Z2	1.5735	$66.94
77370	Radiation physics consult	Z2	1.5735	$66.94
77371	Srs, multisource	Z3	24.3429	$1,035.62
77399	External radiation dosimetry	Z2	1.5735	$66.94
77401	Radiation treatment delivery	Z3	0.9094	$38.69
77402	Radiation treatment delivery	Z2	1.4826	$63.07
77403	Radiation treatment delivery	Z2	1.4826	$63.07
77404	Radiation treatment delivery	Z2	1.4826	$63.07
77406	Radiation treatment delivery	Z2	1.4826	$63.07
77407	Radiation treatment delivery	Z2	1.4826	$63.07
77408	Radiation treatment delivery	Z2	1.4826	$63.07
77409	Radiation treatment delivery	Z2	1.4826	$63.07
77411	Radiation treatment delivery	Z2	2.2295	$94.85
77412	Radiation treatment delivery	Z2	2.2295	$94.85
77413	Radiation treatment delivery	Z2	2.2295	$94.85
77414	Radiation treatment delivery	Z2	2.2295	$94.85
77416	Radiation treatment delivery	Z2	2.2295	$94.85

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
77417	Radiology port film(s)	Z3	0.3782	$16.09
77418	Radiation tx delivery, imrt	Z2	5.4731	$232.84
77421	Stereoscopic x-ray guidance	Z2	1.0974	$46.69
77422	Neutron beam tx, simple	Z2	2.2295	$94.85
77423	Neutron beam tx, complex	Z2	2.2295	$94.85
77435	Sbrt management	N1	.....	.....
77470	Special radiation treatment	Z3	4.9813	$211.92
77520	Proton trmt, simple w/o comp	Z2	18.8926	$803.75
77522	Proton trmt, simple w/comp	Z2	18.8926	$803.75
77523	Proton trmt, intermediate	Z2	22.6031	$961.60
77525	Proton treatment, complex	Z2	22.6031	$961.60
77600	Hyperthermia treatment	Z2	3.3461	$142.35
77605	Hyperthermia treatment	Z2	3.3461	$142.35
77610	Hyperthermia treatment	Z2	3.3461	$142.35
77615	Hyperthermia treatment	Z2	3.3461	$142.35
77620	Hyperthermia treatment	Z2	3.3461	$142.35
77750	Infuse radioactive materials	Z3	1.7140	$72.92
77761	Apply intrcav radiat simple	Z3	3.0419	$129.41
77762	Apply intrcav radiat interm	Z3	3.7741	$160.56
77763	Apply intrcav radiat compl	Z3	4.8283	$205.41
77776	Apply interstit radiat simpl	Z3	3.2109	$136.60
77777	Apply interstit radiat inter	Z3	3.8707	$164.67
77778	Apply interstit radiat compl	Z3	5.1261	$218.08
77781	High intensity brachytherapy	Z3	9.7854	$416.30
77782	High intensity brachytherapy	Z2	12.8473	$546.56
77783	High intensity brachytherapy	Z2	12.8473	$546.56
77784	High intensity brachytherapy	Z2	12.8473	$546.56
77789	Apply surface radiation	Z3	0.8530	$36.29
77790	Radiation handling	N1	.....	.....
77799	Radium/radioisotope therapy	Z2	4.8569	$206.63
78000	Thyroid, single uptake	Z3	1.0622	$45.19
78001	Thyroid, multiple uptakes	Z3	1.3520	$57.52
78003	Thyroid suppress/stimul	Z3	1.0622	$45.19
78006	Thyroid imaging with uptake	Z2	2.3432	$99.69
78007	Thyroid image, mult uptakes	Z3	2.1085	$89.70
78010	Thyroid imaging	Z3	2.2692	$96.54
78011	Thyroid imaging with flow	Z2	2.3432	$99.69
78015	Thyroid met imaging	Z3	3.0097	$128.04
78016	Thyroid met imaging/studies	Z2	3.9934	$169.89
78018	Thyroid met imaging, body	Z2	3.9934	$169.89
78020	Thyroid met uptake	Z3	1.1346	$48.27
78070	Parathyroid nuclear imaging	Z2	2.7146	$115.49
78075	Adrenal nuclear imaging	Z2	2.7146	$115.49
78099	Endocrine nuclear procedure	Z2	2.3432	$99.69
78102	Bone marrow imaging, ltd	Z3	2.3336	$99.28
78103	Bone marrow imaging, mult	Z3	3.2431	$137.97
78104	Bone marrow imaging, body	Z2	3.9073	$166.23
78110	Plasma volume, single	Z3	1.1830	$50.33
78111	Plasma volume, multiple	Z3	1.8266	$77.71
78120	Red cell mass, single	Z3	1.4566	$61.97
78121	Red cell mass, multiple	Z3	1.9634	$83.53
78122	Blood volume	Z3	2.6394	$112.29
78130	Red cell survival study	Z3	2.4060	$102.36
78135	Red cell survival kinetics	Z2	3.7562	$159.80
78140	Red cell sequestration	Z3	2.5913	$110.24
78185	Spleen imaging	Z3	2.8808	$122.56
78190	Platelet survival, kinetics	Z2	2.0057	$85.33
78191	Platelet survival	Z2	2.0057	$85.33
78195	Lymph system imaging	Z2	3.9073	$166.23
78199	Blood/lymph nuclear exam	Z2	3.9073	$166.23
78201	Liver imaging	Z3	2.7039	$115.03
78202	Liver imaging with flow	Z3	3.1385	$133.52
78205	Liver imaging (3D)	Z3	4.2811	$182.13
78206	Liver image (3d) with flow	Z2	4.3774	$186.23

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
78215	Liver and spleen imaging	Z3	2.9453	$125.30
78216	Liver & spleen image/flow	Z3	2.3980	$102.02
78220	Liver function study	Z3	2.5833	$109.90
78223	Hepatobiliary imaging	Z2	4.3774	$186.23
78230	Salivary gland imaging	Z3	2.3980	$102.02
78231	Serial salivary imaging	Z3	2.2775	$96.89
78232	Salivary gland function exam	Z3	2.4143	$102.71
78258	Esophageal motility study	Z3	3.2995	$140.37
78261	Gastric mucosa imaging	Z2	3.6526	$155.39
78262	Gastroesophageal reflux exam	Z2	3.6526	$155.39
78264	Gastric emptying study	Z2	3.6526	$155.39
78270	Vit B–12 absorption exam	Z3	1.3278	$56.49
78271	Vit B–12 absrp exam, int fac	Z3	1.3760	$58.54
78272	Vit B–12 absorp, combined	Z3	1.6898	$71.89
78278	Acute GI blood loss imaging	Z2	3.6526	$155.39
78282	GI protein loss exam	Z2	3.6526	$155.39
78290	Meckel's divert exam	Z2	3.6526	$155.39
78291	Leveen/shunt patency exam	Z3	3.4765	$147.90
78299	GI nuclear procedure	Z2	3.6526	$155.39
78300	Bone imaging, limited area	Z3	2.5106	$106.81
78305	Bone imaging, multiple areas	Z3	3.4443	$146.53
78306	Bone imaging, whole body	Z3	3.9029	$166.04
78315	Bone imaging, 3 phase	Z2	3.9174	$166.66
78320	Bone imaging (3D)	Z2	3.9174	$166.66
78399	Musculoskeletal nuclear exam	Z2	3.9174	$166.66
78414	Non-imaging heart function	Z2	4.1265	$175.55
78428	Cardiac shunt imaging	Z3	2.8729	$122.22
78445	Vascular flow imaging	Z2	2.4204	$102.97
78456	Acute venous thrombus image	Z2	2.4204	$102.97
78457	Venous thrombosis imaging	Z2	2.4204	$102.97
78458	Ven thrombosis images, bilat	Z2	2.4204	$102.97
78459	Heart muscle imaging (PET)	Z2	11.8963	$506.10
78460	Heart muscle blood, single	Z3	2.6235	$111.61
78461	Heart muscle blood, multiple	Z3	3.2673	$139.00
78464	Heart image (3d), single	Z2	4.1265	$175.55
78465	Heart image (3d), multiple	Z2	6.5012	$276.58
78466	Heart infarct image	Z3	2.7039	$115.03
78468	Heart infarct image (ef)	Z3	3.7099	$157.83
78469	Heart infarct image (3D)	Z2	4.1265	$175.55
78472	Gated heart, planar, single	Z2	4.1265	$175.55
78473	Gated heart, multiple	Z2	4.9832	$212.00
78478	Heart wall motion add-on	Z3	0.8530	$36.29
78480	Heart function add-on	Z3	0.8530	$36.29
78481	Heart first pass, single	Z3	3.9431	$167.75
78483	Heart first pass, multiple	Z2	4.9832	$212.00
78491	Heart image (pet), single	Z2	11.8963	$506.10
78492	Heart image (pet), multiple	Z2	11.8963	$506.10
78494	Heart image, spect	Z2	4.1265	$175.55
78496	Heart first pass add-on	Z2	1.5054	$64.04
78499	Cardiovascular nuclear exam	Z2	4.1265	$175.55
78580	Lung perfusion imaging	Z2	3.1802	$135.30
78584	Lung V/Q image single breath	Z3	2.2775	$96.89
78585	Lung V/Q imaging	Z2	5.0975	$216.86
78586	Aerosol lung image, single	Z3	2.5670	$109.21
78587	Aerosol lung image, multiple	Z3	3.1305	$133.18
78588	Perfusion lung image	Z3	4.4261	$188.30
78591	Vent image, 1 breath, 1 proj	Z3	2.6637	$113.32
78593	Vent image, 1 proj, gas	Z3	3.1465	$133.86
78594	Vent image, mult proj, gas	Z2	3.1802	$135.30
78596	Lung differential function	Z2	5.0975	$216.86
78599	Respiratory nuclear exam	Z2	3.1802	$135.30
78600	Brain imaging, ltd static	Z3	3.8627	$164.33
78601	Brain imaging, ltd w/flow	Z3	3.3315	$141.73
78605	Brain imaging, complete	Z3	3.1063	$132.15

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
78606	Brain imaging, compl w/flow	Z2	4.6418	$197.48
78607	Brain imaging (3D)	Z2	4.6418	$197.48
78608	Brain imaging (PET)	Z2	13.9166	$592.05
78610	Brain flow imaging only	Z3	2.2855	$97.23
78615	Cerebral vascular flow image	Z3	3.5327	$150.29
78630	Cerebrospinal fluid scan	Z2	3.4923	$148.57
78635	CSF ventriculography	Z2	3.4923	$148.57
78645	CSF shunt evaluation	Z2	3.4923	$148.57
78647	Cerebrospinal fluid scan	Z2	3.4923	$148.57
78650	CSF leakage imaging	Z2	3.4923	$148.57
78660	Nuclear exam of tear flow	Z3	2.4143	$102.71
78699	Nervous system nuclear exam	Z2	4.6418	$197.48
78700	Kidney imaging, morphol	Z3	2.8891	$122.91
78701	Kidney imaging with flow	Z3	3.4041	$144.82
78707	Kflow/funct image w/o drug	Z2	3.4209	$145.54
78708	Kflow/funct image w/drug	Z3	2.9373	$124.96
78709	Kflow/funct image, multiple	Z2	4.0378	$171.78
78710	Kidney imaging (3D)	Z2	3.4209	$145.54
78725	Kidney function study	Z2	1.3754	$58.51
78730	Urinary bladder retention	Z2	0.6102	$25.96
78740	Ureteral reflux study	Z3	2.8649	$121.88
78761	Testicular imaging w/flow	Z3	3.0499	$129.75
78799	Genitourinary nuclear exam	Z2	3.4209	$145.54
78800	Tumor imaging, limited area	Z3	2.9293	$124.62
78801	Tumor imaging, mult areas	Z3	3.9271	$167.07
78802	Tumor imaging, whole body	Z2	3.9934	$169.89
78803	Tumor imaging (3D)	Z2	3.9934	$169.89
78804	Tumor imaging, whole body	Z2	5.9245	$252.05
78805	Abscess imaging, ltd area	Z3	2.8729	$122.22
78806	Abscess imaging, whole body	Z2	3.9934	$169.89
78807	Nuclear localization/abscess	Z2	3.9934	$169.89
78811	Tumor imaging (pet), limited	Z2	13.9166	$592.05
78812	Tumor image (pet)/skul-thigh	Z2	13.9166	$592.05
78813	Tumor image (pet) full body	Z2	13.9166	$592.05
78814	Tumor image pet/ct, limited	Z2	15.4552	$657.51
78815	Tumorimage pet/ct skul-thigh	Z2	15.4552	$657.51
78816	Tumor image pet/ct full body	Z2	15.4552	$657.51
78890	Nuclear medicine data proc	N1		
78891	Nuclear med data proc	N1		
78999	Nuclear diagnostic exam	Z2	1.3754	$58.51
79005	Nuclear rx, oral admin	Z3	1.5370	$65.39
79101	Nuclear rx, iv admin	Z3	1.6094	$68.47
79200	Nuclear rx, intracav admin	Z3	1.6738	$71.21
79300	Nuclr rx, interstit colloid	Z2	3.1779	$135.20
79403	Hematopoietic nuclear tx	Z3	2.5591	$108.87
79440	Nuclear rx, intra-articular	Z3	1.4968	$63.68
79445	Nuclear rx, intra-arterial	Z2	3.1779	$135.20
79999	Nuclear medicine therapy	Z2	3.1779	$135.20
90371	Hep b ig, im	K2		$133.69
90375	Rabies ig, im/sc	K2		$65.44
90376	Rabies ig, heat treated	K2		$70.06
90396	Varicella-zoster ig, im	K2		$122.74
90585	Bcg vaccine, precut	K2		$113.63
90675	Rabies vaccine, im	K2		$146.91
90676	Rabies vaccine, id	K2		$119.86
90708	Measles-rubella vaccine, sc	K2		$45.53
90720	Dtp/hib vaccine, im	K2		$58.70
90727	Plague vaccine, im	K2		$7.13
90733	Meningococcal vaccine, sc	K2		$89.43
90734	Meningococcal vaccine, im	K2		$82.00
90735	Encephalitis vaccine, sc	K2		$99.11
A4218	Sterile saline or water	N1		
A4220	Infusion pump refill kit	N1		
A4248	Chlorhexidine antisept	N1		

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
A4262	Temporary tear duct plug	N1		
A4263	Permanent tear duct plug	N1		
A4270	Disposable endoscope sheath	N1		
A4300	Cath impl vasc access portal	N1		
A4301	Implantable access syst perc	N1		
A4305	Drug delivery system ≧50 ML	N1		
A4306	Drug delivery system ≦50 ml	N1		
A9527	Iodine I-125 sodium iodide	H7		
A9698	Non-rad contrast materialNOC	N1		
C1713	Anchor/screw bn/bn,tis/bn	N1		
C1714	Cath, trans atherectomy, dir	N1		
C1715	Brachytherapy needle	N1		
C1716	Brachytx source, Gold 198	H7		
C1717	Brachytx source, HDR Ir-192	H7		
C1718	Brachytx source, Iodine 125	H7		
C1719	Brachytx sour, Non-HDR Ir-192	H7		
C1720	Brachytx sour, Palladium 103	H7		
C1721	AICD, dual chamber	N1		
C1722	AICD, single chamber	N1		
C1724	Cath, trans atherec, rotation	N1		
C1725	Cath, translumin non-laser	N1		
C1726	Cath, bal dil, non-vascular	N1		
C1727	Cath, bal tis dis, non-vas	N1		
C1728	Cath, brachytx seed adm	N1		
C1729	Cath, drainage	N1		
C1730	Cath, EP, 19 or few elect	N1		
C1731	Cath, EP, 20 or more elec	N1		
C1732	Cath, EP, diag/abl, 3D/vect	N1		
C1733	Cath, EP, othr than cool-tip	N1		
C1750	Cath, hemodialysis, long-term	N1		
C1751	Cath, inf, per/cent/midline	N1		
C1752	Cath, hemodialysis, short-term	N1		
C1753	Cath, intravas ultrasound	N1		
C1754	Catheter, intradiscal	N1		
C1755	Catheter, intraspinal	N1		
C1756	Cath, pacing, transesoph	N1		
C1757	Cath, thrombectomy/embolect	N1		
C1758	Catheter, ureteral	N1		
C1759	Cath, intra echocardiography	N1		
C1760	Closure dev, vasc	N1		
C1762	Conn tiss, human (inc fascia)	N1		
C1763	Conn tiss, non-human	N1		
C1764	Event recorder, cardiac	N1		
C1765	Adhesion barrier	N1		
C1766	Intro/sheath, strble, non-peel	N1		
C1767	Generator, neuro non-recharg	N1		
C1768	Graft, vascular	N1		
C1769	Guide wire	N1		
C1770	Imaging coil, MR, insertable	N1		
C1771	Rep dev, urinary, w/sling	N1		
C1772	Infusion pump, programmable	N1		
C1773	Ret dev, insertable	N1		
C1776	Joint device (implantable)	N1		
C1777	Lead, AICD, endo single coil	N1		
C1778	Lead, neurostimulator	N1		
C1779	Lead, pmkr, transvenous VDD	N1		
C1780	Lens, intraocular (new tech)	N1		
C1781	Mesh (implantable)	N1		
C1782	Morcellator	N1		
C1783	Ocular imp, aqueous drain de	N1		
C1784	Ocular dev, intraop, det ret	N1		
C1785	Pmkr, dual, rate-resp	N1		
C1786	Pmkr, single, rate-resp	N1		
C1787	Patient progr, neurostim	N1		

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
C1788	Port, indwelling, imp	N1		
C1789	Prosthesis, breast, imp	N1		
C1813	Prosthesis, penile, inflatab	N1		
C1814	Retinal tamp, silicone oil	N1		
C1815	Pros, urinary sph, imp	N1		
C1816	Receiver/transmitter, neuro	N1		
C1817	Septal defect imp sys	N1		
C1818	Integrated keratoprosthesis	N1		
C1819	Tissue localization-excision	N1		
C1820	Generator neuro rechg bat sy	J7		
C1821	Interspinous implant	J7		
C1874	Stent, coated/cov w/del sys	N1		
C1875	Stent, coated/cov w/o del sy	N1		
C1876	Stent, non-coa/non-cov w/del	N1		
C1877	Stent, non-coat/cov w/o del	N1		
C1878	Matrl for vocal cord	N1		
C1879	Tissue marker, implantable	N1		
C1880	Vena cava filter	N1		
C1881	Dialysis access system	N1		
C1882	AICD, other than sing/dual	N1		
C1883	Adapt/ext, pacing/neuro lead	N1		
C1884	Embolization Protect syst	N1		
C1885	Cath, translumin angio laser	N1		
C1887	Catheter, guiding	N1		
C1888	Endovas non-cardiac abl cath	N1		
C1891	Infusion pump, non-prog, perm	N1		
C1892	Intro/sheath, fixed, peel-away	N1		
C1893	Intro/sheath, fixed, non-peel	N1		
C1894	Intro/sheath, non-laser	N1		
C1895	Lead, AICD, endo dual coil	N1		
C1896	Lead, AICD, non sing/dual	N1		
C1897	Lead, neurostim test kit	N1		
C1898	Lead, pmkr, other than trans	N1		
C1899	Lead, pmkr/AICD combination	N1		
C1900	Lead, coronary venous	N1		
C2614	Probe, perc lumb disc	N1		
C2615	Sealant, pulmonary, liquid	N1		
C2616	Brachytx source, Yttrium-90	H7		
C2617	Stent, non-cor, tem w/o del	N1		
C2618	Probe, cryoablation	N1		
C2619	Pmkr, dual, non rate-resp	N1		
C2620	Pmkr, single, non rate-resp	N1		
C2621	Pmkr, other than sing/dual	N1		
C2622	Prosthesis, penile, non-inf	N1		
C2625	Stent, non-cor, tem w/del sy	N1		
C2626	Infusion pump, non-prog, temp	N1		
C2627	Cath, suprapubic/cystoscopic	N1		
C2628	Catheter, occlusion	N1		
C2629	Intro/sheath, laser	N1		
C2630	Cath, EP, cool-tip	N1		
C2631	Rep dev, urinary, w/o sling	N1		
C2633	Brachytx source, Cesium-131	H7		
C2634	Brachytx source, HA, I-125	H7		
C2635	Brachytx source, HA, P-103	H7		
C2636	Brachytx linear source, P-103	H7		
C2637	Brachytx, Ytterbium–169	H7		
C8900	MRA w/cont, abd	Z2	6.1231	$260.50
C8901	MRA w/o cont, abd	Z2	5.6745	$241.41
C8902	MRA w/o fol w/cont, abd	Z2	8.1155	$345.26
C8903	MRI w/cont, breast, uni	Z2	6.1231	$260.50
C8904	MRI w/o cont, breast, uni	Z2	5.6745	$241.41
C8905	MRI w/o fol w/cont, brst, un	Z2	8.1155	$345.26
C8906	MRI w/cont, breast, bi	Z2	6.1231	$260.50
C8907	MRI w/o cont, breast, bi	Z2	5.6745	$241.41

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
C8908	MRI w/o fol w/cont, breast,	Z2	8.1155	$345.26
C8909	MRA w/cont, chest	Z2	6.1231	$260.50
C8910	MRA w/o cont, chest	Z2	5.6745	$241.41
C8911	MRA w/o fol w/cont, chest	Z2	8.1155	$345.26
C8912	MRA w/cont, lwr ext	Z2	6.1231	$260.50
C8913	MRA w/o cont, lwr ext	Z2	5.6745	$241.41
C8914	MRA w/o fol w/cont, lwr ext	Z2	8.1155	$345.26
C8918	MRA w/cont, pelvis	Z2	6.1231	$260.50
C8919	MRA w/o cont, pelvis	Z2	5.6745	$241.41
C8920	MRA w/o fol w/cont, pelvis	Z2	8.1155	$345.26
C9003	Palivizumab, per 50 mg	K2		$684.43
C9113	Inj pantoprazole sodium, via	N1		
C9121	Injection, argatroban	K2		$18.04
C9232	Injection, idursulfase	K2		$455.03
C9233	Injection, ranibizumab	K2		$2,030.92
C9234	Inj, alglucosidase alfa	K2		$127.20
C9235	Injection, panitumumab	K2		$84.80
C9350	Porous collagen tube per cm	K2		$485.91
C9351	Acellular derm tissue percm2	K2		$41.59
C9399	Unclassified drugs or biolog	K7		
E0616	Cardiac event recorder	N1		
E0749	Elec osteogen stim implanted	N1		
E0782	Non-programble infusion pump	N1		
E0783	Programmable infusion pump	N1		
E0785	Replacement impl pump cathet	N1		
E0786	Implantable pump replacement	N1		
G0130	Single energy x-ray study	Z3	0.5150	$21.91
G0173	Linear acc stereo radsur com	Z2	63.3759	$2,696.20
G0251	Linear acc based stero radio	Z2	20.3224	$864.58
G0288	Recon, CTA for surg plan	Z2	3.2393	$137.81
G0339	Robot lin-radsurg com, first	Z2	63.3759	$2,696.20
G0340	Robt lin-radsurg fractx 2–5	Z2	43.0297	$1,830.61
J0120	Tetracyclin injection	N1		
J0128	Abarelix injection	K2		$68.62
J0129	Abatacept injection	K2		$18.69
J0130	Abciximab injection	K2		$413.16
J0132	Acetylcysteine injection	K2		$1.95
J0133	Acyclovir injection	N1		
J0135	Adalimumab injection	K2		$319.03
J0150	Injection adenosine 6 MG	K2		$22.86
J0152	Adenosine injection	K2		$69.16
J0170	Adrenalin epinephrin inject	N1		
J0180	Agalsidase beta injection	K2		$127.20
J0190	Inj biperiden lactate/5 mg	K2		$88.15
J0200	Alatrofloxacin mesylate	N1		
J0205	Alglucerase injection	K2		$39.22
J0207	Amifostine	K2		$480.64
J0210	Methyldopate hcl injection	K2		$10.11
J0215	Alefacept	K2		$26.07
J0256	Alpha 1 proteinase inhibitor	K2		$3.28
J0278	Amikacin sulfate injection	N1		
J0280	Aminophyllin 250 MG inj	N1		
J0282	Amiodarone HCl	N1		
J0285	Amphotericin B	N1		
J0287	Amphotericin b lipid complex	K2		$10.38
J0288	Ampho b cholesteryl sulfate	K2		$12.00
J0289	Amphotericin b liposome inj	K2		$17.24
J0290	Ampicillin 500 MG inj	N1		
J0295	Ampicillin sodium per 1.5 gm	N1		
J0300	Amobarbital 125 MG inj	N1		
J0330	Succinycholine chloride inj	N1		
J0348	Anadulafungin injection	K2		$1.91
J0350	Injection anistreplase 30 u	K2		$2,693.80
J0360	Hydralazine hcl injection	N1		

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J0364	Apomorphine hydrochloride	K2		$2.99
J0365	Aprotonin, 10,000 kiu	K2		$2.52
J0380	Inj metaraminol bitartrate	K2		$15.67
J0390	Chloroquine injection	N1		
J0395	Arbutamine HCl injection	K2		$182.40
J0456	Azithromycin	N1		
J0460	Atropine sulfate injection	N1		
J0470	Dimecaprol injection	N1		
J0475	Baclofen 10 MG injection	K2		$197.04
J0476	Baclofen intrathecal trial	K2		$71.59
J0480	Basiliximab	K2		$1,359.97
J0500	Dicyclomine injection	N1		
J0515	Inj benztropine mesylate	N1		
J0520	Bethanechol chloride inject	N1		
J0530	Penicillin g benzathine inj	N1		
J0540	Penicillin g benzathine inj	N1		
J0550	Penicillin g benzathine inj	N1		
J0560	Penicillin g benzathine inj	N1		
J0570	Penicillin g benzathine inj	N1		
J0580	Penicillin g benzathine inj	N1		
J0583	Bivalirudin	K2		$1.74
J0585	Botulinum toxin a per unit	K2		$5.10
J0587	Botulinum toxin type B	K2		$8.37
J0592	Buprenorphine hydrochloride	N1		
J0594	Busulfan injection	K2		$8.89
J0595	Butorphanol tartrate 1 mg	N1		
J0600	Edetate calcium disodium inj	K2		$40.19
J0610	Calcium gluconate injection	N1		
J0620	Calcium glycer & lact/10 ML	N1		
J0630	Calcitonin salmon injection	N1		
J0636	Inj calcitriol per 0.1 mcg	N1		
J0637	Caspofungin acetate	K2		$30.35
J0640	Leucovorin calcium injection	N1		
J0670	Inj mepivacaine HCL/10 ml	N1		
J0690	Cefazolin sodium injection	N1		
J0692	Cefepime HCl for injection	N1		
J0694	Cefoxitin sodium injection	N1		
J0696	Ceftriaxone sodium injection	N1		
J0697	Sterile cefuroxime injection	N1		
J0698	Cefotaxime sodium injection	N1		
J0702	Betamethasone acet&sod phosp	N1		
J0704	Betamethasone sod phosp/4 MG	N1		
J0706	Caffeine citrate injection	K2		$3.36
J0710	Cephapirin sodium injection	N1		
J0713	Inj ceftazidime per 500 mg	N1		
J0715	Ceftizoxime sodium/500 MG	N1		
J0720	Chloramphenicol sodium injec	N1		
J0725	Chorionic gonadotropin/1000u	N1		
J0735	Clonidine hydrochloride	K2		$63.46
J0740	Cidofovir injection	K2		$761.81
J0743	Cilastatin sodium injection	N1		
J0744	Ciprofloxacin iv	N1		
J0745	Inj codeine phosphate /30 MG	N1		
J0760	Colchicine injection	N1		
J0770	Colistimethate sodium inj	N1		
J0780	Prochlorperazine injection	N1		
J0795	Corticorelin ovine triflutal	K2		$4.31
J0800	Corticotropin injection	K2		$127.73
J0835	Inj cosyntropin per 0.25 MG	K2		$63.85
J0850	Cytomegalovirus imm IV /vial	K2		$868.05
J0878	Daptomycin injection	K2		$0.33
J0881	Darbepoetin alfa, non-esrd	K2		$3.14
J0885	Epoetin alfa, non-esrd	K2		$9.45
J0894	Decitabine injection	K2		$26.48

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J0895	Deferoxamine mesylate inj	K2		$14.52
J0900	Testosterone enanthate inj	N1		
J0945	Brompheniramine maleate inj	N1		
J0970	Estradiol valerate injection	N1		
J1000	Depo-estradiol cypionate inj	N1		
J1020	Methylprednisolone 20 MG inj	N1		
J1030	Methylprednisolone 40 MG inj	N1		
J1040	Methylprednisolone 80 MG inj	N1		
J1051	Medroxyprogesterone inj	N1		
J1060	Testosterone cypionate 1 ML	N1		
J1070	Testosterone cypionat 100 MG	N1		
J1080	Testosterone cypionat 200 MG	N1		
J1094	Inj dexamethasone acetate	N1		
J1100	Dexamethasone sodium phos	N1		
J1110	Inj dihydroergotamine mesylt	N1		
J1120	Acetazolamid sodium injectio	N1		
J1160	Digoxin injection	N1		
J1162	Digoxin immune fab (ovine)	K2		$516.35
J1165	Phenytoin sodium injection	N1		
J1170	Hydromorphone injection	N1		
J1180	Dyphylline injection	N1		
J1190	Dexrazoxane HCl injection	K2		$174.07
J1200	Diphenhydramine hcl injectio	N1		
J1205	Chlorothiazide sodium inj	K2		$123.84
J1212	Dimethyl sulfoxide 50% 50 ML	N1		
J1230	Methadone injection	N1		
J1240	Dimenhydrinate injection	N1		
J1245	Dipyridamole injection	N1		
J1250	Inj dobutamine HCL/250 mg	N1		
J1260	Dolasetron mesylate	K2		$6.11
J1265	Dopamine injection	N1		
J1270	Injection, doxercalciferol	N1		
J1320	Amitriptyline injection	N1		
J1324	Enfuvirtide injection	K2		$22.91
J1325	Epoprostenol injection	N1		
J1327	Eptifibatide injection	K2		$16.05
J1330	Ergonovine maleate injection	K2		$4.00
J1335	Ertapenem injection	N1		
J1364	Erythro lactobionate /500 MG	N1		
J1380	Estradiol valerate 10 MG inj	N1		
J1390	Estradiol valerate 20 MG inj	N1		
J1410	Inj estrogen conjugate 25 MG	K2		$60.90
J1430	Ethanolamine oleate 100 mg	K2		$79.01
J1435	Injection estrone per 1 MG	N1		
J1436	Etidronate disodium inj	K2		$71.41
J1438	Etanercept injection	K2		$161.55
J1440	Filgrastim 300 mcg injection	K2		$189.47
J1441	Filgrastim 480 mcg injection	K2		$300.58
J1450	Fluconazole	N1		
J1451	Fomepizole, 15 mg	K2		$12.39
J1452	Intraocular Fomivirsen na	K2		$237.50
J1455	Foscarnet sodium injection	K2		$10.20
J1457	Gallium nitrate injection	N1		
J1458	Galsulfase injection	K2		$299.92
J1460	Gamma globulin 1 CC inj	K2		$11.42
J1562	Immune globulin subcutaneous	K2		$12.72
J1565	RSV-ivig	K2		$16.18
J1566	Immune globulin, powder	K2		$25.72
J1567	Immune globulin, liquid	K2		$30.57
J1570	Ganciclovir sodium injection	N1		
J1580	Garamycin gentamicin inj	N1		
J1590	Gatifloxacin injection	N1		
J1595	Injection glatiramer acetate	N1		
J1600	Gold sodium thiomaleate inj	N1		

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J1610	Glucagon hydrochloride/1 MG	K2		$66.27
J1620	Gonadorelin hydroch/ 100 mcg	K2		$180.30
J1626	Granisetron HCl injection	K2		$7.50
J1630	Haloperidol injection	N1		
J1631	Haloperidol decanoate inj	N1		
J1640	Hemin, 1 mg	K2		$6.80
J1642	Inj heparin sodium per 10 u	N1		
J1644	Inj heparin sodium per 1000u	N1		
J1645	Dalteparin sodium	N1		
J1650	Inj enoxaparin sodium	N1		
J1652	Fondaparinux sodium	N1		
J1655	Tinzaparin sodium injection	K2		$2.45
J1670	Tetanus immune globulin inj	K2		$97.26
J1700	Hydrocortisone acetate inj	N1		
J1710	Hydrocortisone sodium ph inj	N1		
J1720	Hydrocortisone sodium succ i	N1		
J1730	Diazoxide injection	K2		$114.32
J1740	Ibandronate sodium injection	K2		$138.71
J1742	Ibutilide fumarate injection	K2		$266.92
J1745	Infliximab injection	K2		$53.76
J1751	Iron dextran 165 injection	K2		$11.72
J1752	Iron dextran 267 injection	K2		$10.42
J1756	Iron sucrose injection	K2		$0.37
J1785	Injection imiglucerase /unit	K2		$3.92
J1790	Droperidol injection	N1		
J1800	Propranolol injection	N1		
J1815	Insulin injection	N1		
J1817	Insulin for insulin pump use	N1		
J1830	Interferon beta-1b /.25 MG	K2		$84.92
J1835	Itraconazole injection	K2		$38.41
J1840	Kanamycin sulfate 500 MG inj	N1		
J1850	Kanamycin sulfate 75 MG inj	N1		
J1885	Ketorolac tromethamine inj	N1		
J1890	Cephalothin sodium injection	N1		
J1931	Laronidase injection	K2		$23.87
J1940	Furosemide injection	N1		
J1945	Lepirudin	K2		$154.89
J1950	Leuprolide acetate /3.75 MG	K2		$433.92
J1956	Levofloxacin injection	N1		
J1960	Levorphanol tartrate inj	N1		
J1980	Hyoscyamine sulfate inj	N1		
J1990	Chlordiazepoxide injection	N1		
J2001	Lidocaine injection	N1		
J2010	Lincomycin injection	N1		
J2020	Linezolid injection	K2		$25.17
J2060	Lorazepam injection	N1		
J2150	Mannitol injection	N1		
J2170	Mecasermin injection	K2		$11.93
J2175	Meperidine hydrochl /100 MG	N1		
J2180	Meperidine/promethazine inj	N1		
J2185	Meropenem	K2		$3.71
J2210	Methylergonovin maleate inj	N1		
J2248	Micafungin sodium injection	K2		$1.71
J2250	Inj midazolam hydrochloride	N1		
J2260	Inj milrinone lactate/5 MG	N1		
J2270	Morphine sulfate injection	N1		
J2271	Morphine so4 injection 100 mg	N1		
J2275	Morphine sulfate injection	N1		
J2278	Ziconotide injection	K2		$6.52
J2280	Inj, moxifloxacin 100 mg	N1		
J2300	Inj nalbuphine hydrochloride	N1		
J2310	Inj naloxone hydrochloride	N1		
J2315	Naltrexone, depot form	K2		$1.90
J2320	Nandrolone decanoate 50 MG	N1		

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J2321	Nandrolone decanoate 100 MG	N1		
J2322	Nandrolone decanoate 200 MG	N1		
J2325	Nesiritide injection	K2		$31.66
J2353	Octreotide injection, depot	K2		$96.77
J2354	Octreotide inj, non-depot	N1		
J2355	Oprelvekin injection	K2		$247.31
J2357	Omalizumab injection	K2		$16.95
J2360	Orphenadrine injection	N1		
J2370	Phenylephrine hcl injection	N1		
J2400	Chloroprocaine hcl injection	N1		
J2405	Ondansetron hcl injection	K2		$3.40
J2410	Oxymorphone hcl injection	N1		
J2425	Palifermin injection	K2		$11.43
J2430	Pamidronate disodium/30 MG	K2		$30.78
J2440	Papaverin hcl injection	N1		
J2460	Oxytetracycline injection	N1		
J2469	Palonosetron HCl	K2		$16.00
J2501	Paricalcitol	N1		
J2503	Pegaptanib sodium injection	K2		$1,054.70
J2504	Pegademase bovine, 25 iu	K2		$177.83
J2505	Injection, pegfilgrastim 6mg	K2		$2,163.33
J2510	Penicillin g procaine inj	N1		
J2513	Pentastarch 10% solution	N1		
J2515	Pentobarbital sodium inj	N1		
J2540	Penicillin g potassium inj	N1		
J2543	Piperacillin/tazobactam	N1		
J2550	Promethazine hcl injection	N1		
J2560	Phenobarbital sodium inj	N1		
J2590	Oxytocin injection	N1		
J2597	Inj desmopressin acetate	N1		
J2650	Prednisolone acetate inj	N1		
J2670	Totazoline hcl injection	N1		
J2675	Inj progesterone per 50 MG	N1		
J2680	Fluphenazine decanoate 25 MG	N1		
J2690	Procainamide hcl injection	N1		
J2700	Oxacillin sodium injection	N1		
J2710	Neostigmine methylslfte inj	N1		
J2720	Inj protamine sulfate/10 MG	N1		
J2725	Inj protirelin per 250 mcg	N1		
J2730	Pralidoxime chloride inj	N1		
J2760	Phentolaine mesylate inj	N1		
J2765	Metoclopramide hcl injection	N1		
J2770	Quinupristin/dalfopristin	K2		$117.81
J2780	Ranitidine hydrochloride inj	N1		
J2783	Rasburicase	K2		$132.53
J2788	Rho d immune globulin 50 mcg	K2		$26.66
J2790	Rho d immune globulin inj	K2		$81.48
J2792	Rho(D) immune globulin h, sd	K2		$15.91
J2794	Risperidone, long acting	K2		$4.85
J2795	Ropivacaine HCl injection	N1		
J2800	Methocarbamol injection	N1		
J2805	Sincalide injection	N1		
J2810	Inj theophylline per 40 MG	N1		
J2820	Sargramostim injection	K2		$25.31
J2850	Inj secretin synthetic human	K2		$20.31
J2910	Aurothioglucose injection	N1		
J2916	Na ferric gluconate complex	N1		
J2920	Methylprednisolone injection	N1		
J2930	Methylprednisolone injection	N1		
J2940	Somatrem injection	K2		$168.90
J2941	Somatropin injection	K2		$47.19
J2950	Promazine hcl injection	N1		
J2993	Reteplase injection	K2		$899.51
J2995	Inj streptokinase /250000 IU	K2		$129.75

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J2997	Alteplase recombinant	K2		$32.79
J3000	Streptomycin injection	N1		
J3010	Fentanyl citrate injeciton	N1		
J3030	Sumatriptan succinate / 6 MG	K2		$59.38
J3070	Pentazocine injection	N1		
J3100	Tenecteplase injection	K2		$2,043.40
J3105	Terbutaline sulfate inj	N1		
J3120	Testosterone enanthate inj	N1		
J3130	Testosterone enanthate inj	N1		
J3140	Testosterone suspension inj	N1		
J3150	Testosterone propionate inj	N1		
J3230	Chlorpromazine hcl injection	N1		
J3240	Thyrotropin injection	K2		$765.38
J3243	Tigecycline injection	K2		$0.91
J3246	Tirofiban HCl	K2		$7.73
J3250	Trimethobenzamide hcl inj	N1		
J3260	Tobramycin sulfate injection	N1		
J3265	Injection torsemide 10 mg/ml	N1		
J3280	Thiethylperazine maleate inj	N1		
J3285	Treprostinil injection	K2		$55.89
J3301	Triamcinolone acetonide inj	N1		
J3302	Triamcinolone diacetate inj	N1		
J3303	Triamcinolone hexacetonl inj	N1		
J3305	Inj trimetrexate glucoronate	K2		$145.26
J3310	Perphenazine injection	N1		
J3315	Triptorelin pamoate	K2		$155.44
J3320	Spectinomycn di-hcl inj	K2		$30.08
J3350	Urea injection	K2		$74.16
J3355	Urofollitropin, 75 iu	K2		$50.70
J3360	Diazepam injection	N1		
J3364	Urokinase 5000 IU injection	N1		
J3365	Urokinase 250,000 IU inj	K2		$457.73
J3370	Vancomycin hcl injection	N1		
J3396	Verteporfin injection	K2		$8.92
J3400	Triflupromazine hcl inj	N1		
J3410	Hydroxyzine hcl injection	N1		
J3411	Thiamine hcl 100 mg	N1		
J3415	Pyridoxine hcl 100 mg	N1		
J3420	Vitamin b12 injection	N1		
J3430	Vitamin k phytonadione inj	N1		
J3465	Injection, voriconazole	K2		$4.99
J3470	Hyaluronidase injection	N1		
J3471	Ovine, up to 999 USP units	N1		
J3472	Ovine, 1000 USP units	K2		$135.04
J3473	Hyaluronidase recombinant	K2		$0.40
J3475	Inj magnesium sulfate	N1		
J3480	Inj potassium chloride	N1		
J3485	Zidovudine	N1		
J3486	Ziprasidone mesylate	N1		
J3487	Zoledronic acid	K2		$206.04
J3490	Drugs unclassified injection	N1		
J3530	Nasal vaccine inhalation	N1		
J3590	Unclassified biologics	N1		
J7030	Normal saline solution infus	N1		
J7040	Normal saline solution infus	N1		
J7042	5% dextrose/normal saline	N1		
J7050	Normal saline solution infus	N1		
J7060	5% dextrose/water	N1		
J7070	D5w infusion	N1		
J7100	Dextran 40 infusion	N1		
J7110	Dextran 75 infusion	N1		
J7120	Ringers lactate infusion	N1		
J7130	Hypertonic saline solution	N1		
J7187	Inj Vonwillebrand factor IU	K2		$0.88

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J7189	Factor viia	K2		$1.12
J7190	Factor viii	K2		$0.70
J7191	Factor VIII (porcine)	K2		$0.75
J7192	Factor viii recombinant	K2		$1.07
J7193	Factor IX non-recombinant	K2		$0.89
J7194	Factor ix complex	K2		$0.75
J7195	Factor IX recombinant	K2		$0.99
J7197	Antithrombin iii injection	K2		$1.64
J7198	Anti-inhibitor	K2		$1.36
J7308	Aminolevulinic acid hcl top	K2		$105.43
J7310	Ganciclovir long act implant	K2		$4,752.26
J7311	Fluocinolone acetonide implt	K2		$19,345.00
J7340	Metabolic active D/E tissue	K2		$28.78
J7341	Non-human, metabolic tissue	K2		$1.82
J7342	Metabolically active tissue	K2		$31.66
J7343	Nonmetabolic act d/e tissue	K2		$18.30
J7344	Nonmetabolic active tissue	K2		$89.21
J7345	Non-human, non-metab tissue	K2		$36.10
J7346	Injectable human tissue	K2		$735.38
J7500	Azathioprine oral 50 mg	N1		
J7501	Azathioprine parenteral	K2		$48.44
J7502	Cyclosporine oral 100 mg	K2		$3.60
J7504	Lymphocyte immune globulin	K2		$317.18
J7505	Monoclonal antibodies	K2		$895.15
J7506	Prednisone oral	N1		
J7507	Tacrolimus oral per 1 MG	K2		$3.66
J7509	Methylprednisolone oral	N1		
J7510	Prednisolone oral per 5 mg	N1		
J7511	Antithymocyte globuln rabbit	K2		$327.75
J7513	Daclizumab, parenteral	K2		$299.86
J7515	Cyclosporine oral 25 mg	N1		
J7516	Cyclosporin parenteral 250 mg	N1		
J7517	Mycophenolate mofetil oral	K2		$2.62
J7518	Mycophenolic acid	K2		$2.27
J7520	Sirolimus, oral	K2		$7.22
J7525	Tacrolimus injection	K2		$140.44
J7599	Immunosuppressive drug noc	N1		
J7674	Methacholine chloride, neb	N1		
J7799	Non-inhalation drug for DME	N1		
J8501	Oral aprepitant	K2		$5.07
J8510	Oral busulfan	K2		$2.14
J8520	Capecitabine, oral, 150 mg	K2		$3.97
J8530	Cyclophosphamide oral 25 MG	N1		
J8540	Oral dexamethasone	N1		
J8560	Etoposide oral 50 MG	K2		$29.60
J8597	Antiemetic drug oral NOS	N1		
J8600	Melphalan oral 2 MG	N1		
J8610	Methotrexate oral 2.5 MG	N1		
J8650	Nabilone oral	K2		$16.96
J8700	Temozolomide	K2		$7.41
J9000	Doxorubic hcl 10 MG vl chemo	K2		$6.31
J9001	Doxorubicin hcl liposome inj	K2		$389.48
J9010	Alemtuzumab injection	K2		$541.20
J9015	Aldesleukin/single use vial	K2		$762.98
J9017	Arsenic trioxide	K2		$34.17
J9020	Asparaginase injection	K2		$54.72
J9025	Azacitidine injection	K2		$4.30
J9027	Clofarabine injection	K2		$116.75
J9031	Bcg live intravesical vac	K2		$110.67
J9035	Bevacizumab injection	K2		$57.53
J9040	Bleomycin sulfate injection	K2		$35.85
J9041	Bortezomib injection	K2		$32.68
J9045	Carboplatin injection	K2		$8.46
J9050	Carmus bischl nitro inj	K2		$139.84

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
J9055	Cetuximab injection	K2		$49.81
J9060	Cisplatin 10 MG injection	N1		
J9065	Inj cladribine per 1 MG	K2		$36.12
J9070	Cyclophosphamide 100 MG inj	N1		
J9093	Cyclophosphamide lyophilized	K2		$1.99
J9098	Cytarabine liposome	K2		$395.04
J9100	Cytarabine hcl 100 MG inj	N1		
J9120	Dactinomycin actinomycin d	K2		$493.43
J9130	Dacarbazine 100 mg inj	K2		$5.25
J9150	Daunorubicin	K2		$20.47
J9151	Daunorubicin citrate liposom	K2		$55.92
J9160	Denileukin diftitox, 300 mcg	K2		$1,406.59
J9165	Diethylstilbestrol injection	N1		
J9170	Docetaxel	K2		$306.81
J9175	Elliotts b solution per ml	N1		
J9178	Inj, epirubicin hcl, 2 mg	K2		$21.21
J9181	Etoposide 10 MG inj	N1		
J9185	Fludarabine phosphate inj	K2		$236.44
J9190	Fluorouracil injection	N1		
J9200	Floxuridine injection	K2		$51.31
J9201	Gemcitabine HCl	K2		$125.16
J9202	Goserelin acetate implant	K2		$198.68
J9206	Irinotecan injection	K2		$126.00
J9208	Ifosfomide injection	K2		$46.59
J9209	Mesna injection	K2		$8.97
J9211	Idarubicin hcl injection	K2		$304.61
J9212	Interferon alfacon–1	K2		$4.65
J9213	Interferon alfa–2a inj	K2		$37.89
J9214	Interferon alfa–2b inj	K2		$13.88
J9215	Interferon alfa–n3 inj	K2		$9.12
J9216	Interferon gamma 1–b inj	K2		$289.87
J9217	Leuprolide acetate suspnsion	K2		$229.50
J9218	Leuprolide acetate injeciton	K2		$8.88
J9219	Leuprolide acetate implant	K2		$1,713.12
J9225	Histrelin implant	K2		$1,460.77
J9230	Mechlorethamine hcl inj	K2		$141.61
J9245	Inj melphalan hydrochl 50 MG	K2		$1,284.12
J9250	Methotrexate sodium inj	N1		
J9261	Nelarabine injection	K2		$83.33
J9263	Oxaliplatin	K2		$8.97
J9264	Paclitaxel protein bound	K2		$8.73
J9265	Paclitaxel injection	K2		$12.59
J9266	Pegaspargase/singl dose vial	K2		$1,683.49
J9268	Pentostatin injection	K2		$1,934.91
J9270	Plicamycin (mithramycin) inj	K2		$172.41
J9280	Mitomycin 5 MG inj	K2		$16.13
J9293	Mitoxantrone hydrochl / 5 MG	K2		$168.23
J9300	Gemtuzumab ozogamicin	K2		$2,356.98
J9305	Pemetrexed injection	K2		$43.79
J9310	Rituximab cancer treatment	K2		$496.22
J9320	Streptozocin injection	K2		$153.73
J9340	Thiotepa injection	K2		$40.70
J9350	Topotecan	K2		$830.74
J9355	Trastuzumab	K2		$57.87
J9357	Valrubicin, 200 mg	K2		$77.96
J9360	Vinblastine sulfate inj	N1		
J9370	Vincristine sulfate 1 MG inj	N1		
J9390	Vinorelbine tartrate/10 mg	K2		$20.07
J9395	Injection, Fulvestrant	K2		$80.56
J9600	Porfimer sodium	K2		$2,563.31
J9999	Chemotherapy drug	N1		
L8600	Implant breast silicone/eq	N1		
L8603	Collagen imp urinary 2.5 ml	N1		
L8606	Synthetic implnt urinary 1ml	N1		

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
L8609	Artificial cornea	N1		
L8610	Ocular implant	N1		
L8612	Aqueous shunt prosthesis	N1		
L8613	Ossicular implant	N1		
L8614	Cochlear device	N1		
L8630	Metacarpophalangeal implant	N1		
L8631	MCP joint repl 2 pc or more	N1		
L8641	Metatarsal joint implant	N1		
L8642	Hallux implant	N1		
L8658	Interphalangeal joint spacer	N1		
L8659	Interphalangeal joint repl	N1		
L8670	Vascular graft, synthetic	N1		
L8682	Implt neurostim radiofq rec	N1		
L8690	Aud osseo dev, int/ext comp	J7		
L8699	Prosthetic implant NOS	N1		
Q0163	Diphenhydramine HCl 50mg	N1		
Q0164	Prochlorperazine maleate 5mg	N1		
Q0166	Granisetron HCl 1 mg oral	K2		$44.87
Q0167	Dronabinol 2.5 mg oral	N1		
Q0169	Promethazine HCl 12.5 mg oral	N1		
Q0171	Chlorpromazine HCl 10 mg oral	N1		
Q0173	Trimethobenzamide HCl 250 mg	N1		
Q0174	Thiethylperazine maleate 10 mg	N1		
Q0175	Perphenazine 4 mg oral	N1		
Q0177	Hydroxyzine pamoate 25 mg	N1		
Q0179	Ondansetron HCl 8 mg oral	K2		$36.55
Q0180	Dolasetron mesylate oral	K2		$47.52
Q0515	Sermorelin acetate injection	K2		$1.75
Q1003	Ntiol category 3	L6		$50.00
Q2004	Bladder calculi irrig sol	N1		
Q2009	Fosphenytoin, 50 mg	K2		$5.66
Q2017	Teniposide, 50 mg	K2		$264.09
Q3025	IM inj interferon beta 1–a	K2		$114.57
Q4079	Natalizumab injection	K2		$7.52
Q4083	Hyalgan/supartz inj per dose	K2		$104.85
Q4084	Synvisc inj per dose	K2		$186.66
Q4085	Euflexxa inj per dose	K2		$115.16
Q4086	Orthovisc inj per dose	K2		$198.34
Q9945	LOCM ≦149 mg/ml iodine, 1 ml	K2		$0.42
Q9946	LOCM 150–199 mg/ml iodine,1 ml	K2		$1.95
Q9947	LOCM 200–249 mg/ml iodine,1 ml	K2		$1.33
Q9948	LOCM 250–299 mg/ml iodine,1 ml	K2		$0.36
Q9949	LOCM 300–349 mg/ml iodine,1 ml	K2		$0.37
Q9950	LOCM 350–399 mg/ml iodine,1 ml	K2		$0.22
Q9951	LOCM ≧ 400 mg/ml iodine,1 ml	K2		$0.22
Q9952	Inj Gad-base MR contrast,1 ml	K2		$2.82
Q9953	Inj Fe-based MR contrast,1 ml	K2		$30.41
Q9954	Oral MR contrast, 100 ml	K2		$8.82
Q9955	Inj perflexane lip micros, ml	K2		$12.96
Q9956	Inj octafluoropropane mic, ml	K2		$49.61
Q9957	Inj perflutren lip micros, ml	K2		$61.55
Q9958	HOCM ≦149 mg/ml iodine, 1ml	N1		
Q9959	HOCM 150–199 mg/ml iodine, 1ml	N1		
Q9960	HOCM 200–249 mg/ml iodine, 1 ml	N1		
Q9961	HOCM 250–299 mg/ml iodine, 1ml	N1		
Q9962	HOCM 300–349 mg/ml iodine, 1 ml	N1		
Q9963	HOCM 350–399 mg/ml iodine, 1ml	N1		
Q9964	HOCM≧ 400 mg/ml iodine, 1 ml	N1		
V2630	Anter chamber intraocul lens	N1		
V2631	Iris support intraoclr lens	N1		
V2632	Post chmbr intraocular lens	N1		
V2785	Corneal tissue processing	F4		

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

ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARYSERVICES INTEGRAL TO COVERED SURGICAL PROCEDURES FOR CY 2008 (INCLUDING ANCILLARY SERVICES FOR WHICH PAYMENT IS PACKAGED)—Continued

HCPCS code	Short descriptor	Payment indicator	Estimated CY 2008 payment weights	Estimated CY 2008 payment
V2790	Amniotic membrane	N1	.....	.....

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

ADDENDUM DD1.—ILLUSTRATIVE ASC PAYMENT INDICATORS

Indicator	Payment indicator definition
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
F4	Corneal tissue acquisition; paid at reasonable cost.
G2	Non office-based surgical procedure added to ASC list in CY 2008 or later; payment based on OPPS relative payment weight.
H7	Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
H8	Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate.
J7	OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
J8	Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate.
K2	Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
K7	Unclassified drugs and biologicals; payment contractor-priced.
L6	New Technology Intraocular Lens (NTIOL); special payment.
N1	Packaged procedure/item; no separate payment made.
P2	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
R2	Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
Z2	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
Z3	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

[FR Doc. 07–3490 Filed 7–16–07; 4:00 pm]

BILLING CODE 4120–01–P