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Centers for Medicare & Medicaid Services

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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.

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SUPPLEMENTARY INFORMATION:

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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
 OPPTS [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

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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.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 OPSS 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 OPSS-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 OPSS. The GAO's analysis also found that procedures in the ASC setting had substantially lower costs than those same procedures in the HOPD. While ASC costs for individual procedures varied, in general, the median costs for procedures were lower in ASCs, relative to the median costs of their APC groups, than the median costs for the same procedures in 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 OPSS procedures was 1.04.

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

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

of responding ASCs was 43 percent to 57 percent of total costs.

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

Comment: 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 OPSS 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 OPSS/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 OPSS/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 OPSS/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 OPSS/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 OPSS inpatient list, that are not eligible for separate payment under the OPSS, 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 OPSS and, to the extent it is reasonable to do so, we proposed that the revised ASC payment system parallel the OPSS 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 OPSS 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 OPSS, 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 OPFS. 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 OPSS. 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 OPSS. 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 OPSS inpatient list, that is, those procedures designated as requiring inpatient care under § 419.22(n). (See Addendum E to the CY 2007 OPSS/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 OPSS 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 OPPI 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 OPPIs 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 OPSS that will require hospitals to meet quality reporting standards to receive the full OPSS 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 OPSS 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 OPSS

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 OPSS, 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 OPSS. Packaged CPT codes under the OPSS are identified by status indicator "N" in Addendum B of the CY 2007 OPSS/ASC final rule with comment period (71 FR 68283 through 68384), and their OPSS 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 OPSS 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 OPSS, 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 safely 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 OPPI 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 OPPI 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 OPPI inpatient list; (3) not packaged under the OPPI; (4) not CPT unlisted surgical procedure codes; and (5) recognized for separate payment under the OPPI. 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 ... | Arterectomy, 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 OPSS but that are excluded from the ASC list of covered surgical procedures. This illustrative list does not include those procedures that are on the OPSS inpatient list, packaged under the OPSS, 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 OPSS/ASC annual rulemaking cycle.

TABLE 2.—ILLUSTRATIVE LIST OF SURGICAL PROCEDURES PAYABLE UNDER THE OPSS (NOT ON THE OPSS INPATIENT LIST, NOT PACKAGED UNDER THE OPSS 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 OPSS (NOT ON THE OPSS INPATIENT LIST, NOT PACKAGED UNDER THE OPSS 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/scope. |
| 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 OPPTS (NOT ON THE OPPTS INPATIENT LIST, NOT PACKAGED UNDER THE OPPTS 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. |

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| HCPCS code | Short descriptor |
|------------|--------------------------------|
| 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 abscc. |
| 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. |

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| HCPCS code | Short descriptor |
|------------|--------------------------------|
| 53500 .. | Urethrltys, 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 OPPTS (NOT ON THE OPPTS INPATIENT LIST, NOT PACKAGED UNDER THE OPPTS 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 OPPTS 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 OPPTS payment amount for the procedure in that year. In Addendum AA to the CY 2007 OPPTS/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 OPPTS payment amounts in accordance with the provisions of section 5103 of Public Law 109–171, based on a comparison of the final CY 2007 OPPTS 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 OPPTS/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 OPPTS/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 OPSS

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 OPSS, 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 OPSS, 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS, 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS relative payment weight of 8.7686. Thus, we believed that the relative payment weights established under the OPSS 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 OPSS accurately reflect the relative costs of procedures performed in ASCs. It concluded that the APC groups in the OPSS 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 OPSS 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 OPSS and the revised ASC payment system could be closely linked.

We received a number of comments on our proposal to use the OPSS 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 OPSS 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 OPSS would promote transparency across sites of service in the area of outpatient surgery and would also promote greater alignment and coordination between the OPSS 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 OPSS relative payment weights for specific types of procedures to calculate their ASC payment rates, because they suggested that the OPSS relativity was not correct for some services provided in single specialty ASCs (for example, gastroenterology and pain management procedures). They believed that the OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS and, as such, the payment for any given procedure under the OPSS does not specifically reflect the cost of that procedure in any one facility. Instead, the APC relative payment weights under the OPSS 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 OPSS 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 OPSS procedures attributable to certain APCs and, in many cases, all of the procedures assigned to certain APCs under the OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS, 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 OPSS, payment for prosthetic implants and implantable DME is packaged into the OPSS 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 OPSS 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 OPSS packaging rules to the ASC payment system and to pay under

the revised ASC payment system the same way we pay under the OPSS 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 OPSS.

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 OPSS. They suggested that following the OPSS 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 OPSS 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 OPSS are either packaged or paid separately through an OPSS 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 OPSS payment policy for radiology services under the revised ASC payment system, which either provides separate payment or packages their payment into the OPSS payment for the surgical procedure associated with the radiology services. They indicated that following the OPSS 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 OPSS, 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 OPSS is not included in the OPSS 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 OPSS.

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 OPSS data, we believe that, in most cases, a radiology service that is separately payable under the OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS, any changes to the packaging of radiology services under the OPSS that would alter the OPSS 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 OPSS in that same calendar year. An illustrative listing that includes all radiology services that are separately payable under the CY 2007 OPSS, which will be proposed for updating and then finalized in the CY 2008 OPSS/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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS, so the base OPSS 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 OPSS 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 OPSS 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, OPSS 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 OPSS payment rate for that year or, if specific OPSS 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 OPSS payment rate, without application of the ASC budget neutrality adjustment factor to the OPSS conversion factor. In addition, consistent with the payment of brachytherapy sources under the OPSS, 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 OPSS if possible. A list of brachytherapy sources recognized under the CY 2007 OPSS, for which payment according to the statute is made at charges reduced to cost under the CY 2007 OPSS, 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

OPSS/ASC proposed and final rules, respectively, as will the CY 2008 OPSS 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 OPSS, 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 OPSS 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 OPSS rates for that same year, or if OPSS 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 OPSS) 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 OPSS, CMS pays separately for all pass-through drugs and biologicals, while nonpass-through drugs and biologicals are either packaged or paid separately under the OPSS, 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 OPSS payment policies for both pass-through and nonpass-through drugs and biologicals under the revised ASC payment system. They indicated that following the OPSS 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 OPSS 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 OPSS. 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 OPSS payment rates. Therefore, effective January 1, 2008, we will pay separately for all OPSS pass-through and nonpass-through drugs and biologicals that are separately paid under the OPSS, 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 OPSS, 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 OPSS. We do not believe it would be appropriate to select only a subset of these drugs and biologicals that are separately payable under the OPSS 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 OPSS data, we believe that, in most cases, a drug or biological that is separately payable under the OPSS 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 OPSS for that same year, without the application of the ASC budget neutrality adjustment to the OPSS conversion factor. Because OPSS payment for separately paid drugs and biologicals is provided at the average hospital acquisition cost and is not based upon the application of the OPSS conversion factor to relative payment weights, we believe the OPSS rates should also reflect the typical acquisition cost of these products in the ASC facility setting as well. The OPSS 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 OPSS 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 OPSS, 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 OPSS will be packaged into the payments for the covered surgical procedures with which they are administered, consistent with the current OPSS payment methodology.

As noted above, under the CY 2007 OPSS, 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 OPSS, 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 OPSS rate). Drugs and biologicals for which payment is packaged under the CY 2007 OPSS 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 OPSS/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 OPSS, 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 OPSS 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 OPSS, 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 OPSS, 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 OPSS 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 OPSS 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 OPSS

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 OPSS would also be packaged. In contrast, pass-through status under the OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS packaged into the ASC payment for the associated surgical procedure, when there are either no costs associated with those devices packaged into the base OPSS procedure payment weights or inadequate costs associated only with predecessor devices packaged into the base OPSS weights.

The commenters added that many of the OPSS 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 OPSS; 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 OPSS pass-through program is a statutory requirement of the OPSS 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 OPSS 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 OPSS pass-through devices, the costs of the devices are not fully packaged into the OPSS payment weights upon which the revised ASC payment system is based because the devices are separately paid under the OPSS. 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 OPSS, 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 OPSS 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 OPSS

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 OPSS, 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 OPSS relative payment weight of the associated surgical procedure, thereby packaging payment for all nonpass-through devices, consistent with their treatment under the OPSS. We also proposed to apply an ASC budget neutrality adjustment of 62 percent to the OPSS 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 OPSS. 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 OPSS 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 OPSS and the revised ASC payment system would be aligned, because both systems would provide packaged payment for devices without OPSS 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 OPSS, 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 OPSS, 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 OPSS over the past several years (71 FR 68063 through 68070). There are about 194 OPSS device-dependent procedures, specifically those procedures that are assigned to the 42 OPSS device-dependent APCs under the CY 2007 OPSS, 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS/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 OPSS payment weights under the revised ASC payment system, and the OPSS 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 OPSS device offset percentage to the OPSS national unadjusted payment to acquire the device cost included in the OPSS 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 OPSS 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 OPSS. We believe that use of the OPSS 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 OPSS device

offset percentage is calculated for each OPSS 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 OPSS/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 OPSS 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 OPSS treatment of these procedures in the CY 2008 OPSS/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 OPSS 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 | Insrt/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 | Insert/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 OP/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 OP/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 neurostimulator 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 OPSS 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 OPSS 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 OPSS, indicating that a multiple surgical procedure reduction would not apply. We proposed to update this list annually in the OPSS/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 OPSS 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 OPSS 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 OPSS multiple procedure discounting policy for those surgical procedures assigned to a status indicator other than "T" under the OPSS. We agree with the commenters' general reasoning and further believe that adopting an ASC policy that parallels the OPSS 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 OPSS 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 OPSS, 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 OPSS, CPT codes 19296

and 19297 are assigned to status indicator "T" under the OPSS effective January 1, 2007. As discussed in the CY 2007 OPSS 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 OPSS 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 OPSS 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 OPSS, 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 OPSS 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 OPSS 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/re-infuse. | 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

| HCPSC 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 | Insr/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 sigmoidoscope. | 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 OPSS 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 OPSS 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 OPSS, 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 OPSS 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 OPSS 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 OPSS. The commenters who indicated a preference for the OPSS labor factor did not address the fact that most OPSS HOPDs are staffed 24 hours per day to provide emergency department services and observation care. Other than their request for parity with the OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS, 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 OPSS/ASC final rule with comment period (71 FR 68003), the OPSS 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 OPSS. 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 OPPTS/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 casemix 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 OPSS. 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 OPSS 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 OPSS 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 OPSS/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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPFS 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 OPSS 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 OPSS rates for CY 2008. Through the annual update of the OPSS, 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 OPSS rates in CY 2007 are a small subset of all OPSS 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 OPSS 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 OPSS for purposes of establishing the budget neutrality adjustment under the revised ASC payment system. The beneficiary copayment under the OPSS 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 OPSS, CMS artificially inflated Medicare's estimated payments under the proposed methodology of the revised ASC payment system. They believed that accurately accounting for the OPSS 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 existing 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 OPSS.

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 OPSS 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 OPSS 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 OPSS/ASC proposed rule based on the methodology for calculating budget neutrality established in this final rule and incorporating the proposed CY 2008 OPSS 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 OPSS/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 OPSS 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 OPSS 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 OPSS 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 OPSS/ASC final rule with comment period and take into account the OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 MPFS 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 OPSS payment rates.

To estimate the aggregate amount of expenditures that would be made in CY 2008, we use estimated CY 2008 OPSS 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 OPSS 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 OPSS/ASC proposed rule and finalized in the CY 2008 OPSS/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 OPSS conversion factor by the budget neutrality adjustment. At this time, our estimate of the CY 2008 OPSS conversion factor is \$63,497. Multiplying the estimated CY 2008 OPSS 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 OPSS. 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 OPSS 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 OPSS. 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS, 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 OPSS 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 OPSS 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 OPSS 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 OPSS. 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 OPSS 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 OPSS 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 OPSS.

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 OPSS 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 OPSS.

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 OPSS 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 OPSS 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 OPSS 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 OPSS relative payment weights) such as drugs and biologicals that are separately paid under the OPSS. 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 OPSS 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 OPSS/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 OPSS 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 OPSS. We believed that including the ASC update as part of the OPSS 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 OPSS 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 OPSS 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 OPSS/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 OPSS 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 OPSS and revised ASC payment system. As always, the OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS 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 OPSS. 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 OPSS/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 OPSS information, with application of the estimated CY 2008 OPSS update, including the CY 2007 APC groupings and relative payment weights, the CY

2007 second quarter OPSS payment rates for drugs and biologicals, the CY 2007 OPSS payment methodology for brachytherapy sources, the specification of surgical procedures as subject to OPSS multiple procedure discounting, the designation of surgical procedures as inpatient only under the OPSS, the identification of surgical procedures for which payment is packaged under the OPSS rather than separately paid, and the CY 2007 OPSS 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 OPSS/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 OPSS 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 OPSS/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 OPSS 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 OPSS services that may occur and that would affect the CY 2008 revised ASC payment system between publication of the CY 2008 OPSS/ASC final rule and release of the January 2008 OPSS 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 OPSS payment status indicators that we publish in Addendum D1 as part of the annual OPSS 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, OPSS 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 OPSS/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 OPSS/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 OPSS/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 anesthesiologists’ 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 anesthesiologists’ 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 OPPTS information as updated by the currently estimated CY

2008 OPPTS 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 OPPTS/ASC rules, respectively, and related data files will be included on the CMS Web site as noted above. The OPPTS 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 OPPTS/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 OPSS.

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 OPSS 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 OP/ASC proposed rule based on the methodology for calculating budget neutrality established in this final rule and incorporating the proposed CY 2008 OP/ASC 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 OP/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 OP/ASC 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 OP/ASC 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 OP/ASC. (The only possible instance in which an ASC coinsurance amount could exceed the OP/ASC 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 OP/ASC 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

| HCPSC 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 risk 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 OPSS 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 OPSS 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 (Discussion 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 (Vitreotomy, 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 OPSS 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 OPSS rates. Procedures with current payment rates that are nearly as high as their OPSS rates are affected more negatively under the revised payment system than procedures for which ASC rates have historically been much lower than the comparable OPSS 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 OPSS, 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 OPSS 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 OPSS, 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 OPSS, so the beneficiary coinsurance amount under the ASC payment system almost always will be less than the OPSS 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 OPSS 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.whitehouse.gov/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. | |
| 416.160 | Basis and scope |
| 416.161 | Applicability of this subpart |
| 416.163 | General rules |
| 416.164 | Scope of ASC services |
| 416.166 | Covered surgical procedures |
| 416.167 | Basis of payment |
| 416.171 | Determination of payment rates for ASC services |
| 416.172 | Adjustments to national payment rates |
| 416.173 | Publication of revised payment methodologies and payment rates |
| 416.178 | Limitations on administrative and judicial review |
| 416.179 | Payment and coinsurance reduction for devices replaced without cost or when full credit is received |

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 anesthesiologists' services are made in accordance with Part 414 of this subchapter.

(c) Payment for items and services other than physicians' and anesthesiologists' 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 anesthesiologist 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 OPPTS;

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

(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 OPPTS, 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 OPPTS 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.

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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 |

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

| HCPSC code | Short descriptor | Subject to multiple procedure discounting | 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/leg | 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 spl t grft, trnk/arm/leg | Y | A2 | \$446.00 | 21.4302 | \$911.71 | \$562.43 |
| 15101 | Skin spl t 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 spl t a-grft fac/nck/hf/g | Y | A2 | \$446.00 | 21.4302 | \$911.71 | \$562.43 |
| 15121 | Skn spl t a-grft f/n/hf/g add | Y | A2 | \$510.00 | 21.4302 | \$911.71 | \$610.43 |
| 15130 | Derm autogrft, trnk/arm/leg | Y | A2 | \$446.00 | 21.4302 | \$911.71 | \$562.43 |
| 15131 | Derm autogrft t/a/l add-on | Y | A2 | \$333.00 | 21.4302 | \$911.71 | \$477.68 |
| 15135 | Derm autogrft face/nck/hf/g | Y | A2 | \$446.00 | 21.4302 | \$911.71 | \$562.43 |
| 15136 | Derm autogrft, 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 grft t/a/l +% | Y | A2 | \$333.00 | 21.4302 | \$911.71 | \$477.68 |
| 15155 | Cult epiderm grft, 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/leg | 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 xgrft, 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 xgrft 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 |

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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.

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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 premig 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 |

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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 | Partial mastectomy | Y | A2 | \$510.00 | 19.2788 | \$820.18 | \$587.55 |
| 19302 | P-mastectomy w/in 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 |

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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, leftof | 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 |

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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.

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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.

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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 |

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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 |

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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 | 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 |

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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 |

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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 | \$919.52 |
| 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 kneecap | 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 |

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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 | \$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.

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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.

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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 |

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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 |

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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 |

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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 |

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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 arthroscopy/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 |

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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, super | 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 |

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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 | Larynsop 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 | Larynsop, 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 |

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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 | | | | |

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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 |

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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 | | | | |

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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 |

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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 |

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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.

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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 |

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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 |

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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/endscope 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 |

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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 |

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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 |

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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 |

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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 |

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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 circumcic 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 | Y | 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 |

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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 multi-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 | | | | |

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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 | Transperineal 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 |

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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 hystero-graphy | Y | 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 |

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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 thyroid 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 |

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ADDENDUM AA.—ILLUSTRATIVE ASC COVERED SURGICAL PROCEDURES FOR CY 2008—Continued

[Including surgical procedures for which payment is packaged]

| HCPSC code | Short descriptor | Subject to multiple procedure discounting | 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 discectomy | 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 |

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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, sphenopalatine 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 |

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[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.

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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 |

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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 transsleral 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 |

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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 | \$698.83 |
| 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 |

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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 |

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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 |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 ANCILLARY SERVICES 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 orbit/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 |

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**ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 |

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**ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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, snpl fetus | Z2 | 1.5607 | \$66.40 |
| 76810 | Ob us >= 14 wks, addl fetus | Z3 | 0.9576 | \$40.74 |
| 76811 | Ob us, detailed, snpl 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 |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 ANCILLARY SERVICES 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 absorp 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 |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 | Z2 | 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 | | |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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/embolact | 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 | | |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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-programable infusion pump | N1 | | |
| E0783 | Programmable infusion pump | N1 | | |
| E0785 | Replacement impl pump cathet | N1 | | |
| E0786 | Implantable pump replacement | N1 | | |
| G0130 | Single energy x-ray study | Z3 | 0.5150 | \$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 | Alefcept | 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 | Succinylcholine 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 ANCILLARY SERVICES 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 bethtropine 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 | Corticotropin 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 |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 | | |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 | | |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 methylsifte 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 | Retepase injection | K2 | | \$899.51 |
| J2995 | Inj streptokinase /250000 IU | K2 | | \$129.75 |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 injection | 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 glucuronate | K2 | | \$145.26 |
| J3310 | Perphenazine injection | N1 | | |
| J3315 | Triptorelin pamoate | K2 | | \$155.44 |
| J3320 | Spectinomycin 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 phytanadione 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 |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 | Anti-thrombin 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 acetone 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 globulin 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 | Doxorubicin hcl 10 MG vial 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 | Carmustine nitro inj | K2 | | \$139.84 |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 | | |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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 radiofreq 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 perflorane 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 intraocul lens | N1 | | |
| V2632 | Post chmbr intraocular lens | N1 | | |
| V2785 | Corneal tissue processing | F4 | | |

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ADDENDUM BB.—ILLUSTRATIVE ASC COVERED ANCILLARY SERVICES 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. |

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